Extension for Community Healthcare Outcomes

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| **Primary Care AHEC TeleECHOTM Clinic** Case Presentation Form |

Complete ALL ITEMS on this form and email to: **PrimaryCareECHO@salud.unm.edu**

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| --- | --- |
| 1. Patient Age |  |
| 1. Patient Home Zip Code |  |
| 1. Presenter Phone Number |  |
| 1. Presenter Fax Number |  |
| 1. Presenter Email |  |
| 1. Clinic / Facility Name and City |  |
| 1. When do you want to present your case? *(Date and approximate time)* |  |

*PLEASE NOTE the Project ECHO© case consultants do not create or otherwise establish a provider-patient relationship between any UNMHSC clinician and any patient whose case is being presented in a Project ECHO© setting.*

\* When we receive your case, an email will be sent with a confidential patient ID number (ECHO ID) that must be utilized when identifying your patient during clinic.

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| **Primary Care AHEC TeleECHOTM Clinic** Patient Case Presentation |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| New Case | | | | | | | | Follow Up | | | | | |
| Presenter | | |  | | | | | | | | | Clinical Site | | | | | | | | |  | | | | | | | | | | | |
| ECHO ID # | | |  | | | | | | | | | Age | | |  | | | | | | Gender: M F | | | | | | | | |  |  | |
| Ethnicity: | |  | | Hispanic / Latino | | | | |  | Not Hispanic / Latino | | | | | | | | | | | | |  | | | |  | | | | | |
| Race: | |  | | American Indian / Alaskan Native | | | | | | | | | | | |  | | | Asian | | | | |  | Black / African American | | | | | | | |
|  | |  | | Native Hawaiian / Pacific Islander | | | | | | | | | | | |  | | | White | | | | |  | Multi-Racial | | | | | | | |
|  | |  | | Other | |  | | | | | | | | | | | | | | | | | |  | | | |  | | | | |
| **What is your main question about this patient?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please complete this form limited to pertinent positive and negative information.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Presenting Symptoms/Complaints** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. |  | | | | | | | | | | | | | | | | 4. | | |  | | | | | | | | | | | | | |
| 2. |  | | | | | | | | | | | | | | | | 5. | | |  | | | | | | | | | | | | | |
| 3. |  | | | | | | | | | | | | | | | | 6. | | |  | | | | | | | | | | | | | |
| **Vital Signs** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Blood Pressure | | | | |  | | Heart Rate | | | |  | | SP02 | | | | |  | | | | Respiratory Rate | | | |  | | | Temperature | | |  |
| Pain Scale Rating*(1 to 10)*       BMI | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EKG (as applicable) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Physical Findings** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. |  | | | | | | | | | | | | | | | | 4. | | |  | | | | | | | | | | | | | |
| 2. |  | | | | | | | | | | | | | | | | 5. | | |  | | | | | | | | | | | | | |
| 3. |  | | | | | | | | | | | | | | | | 6. | | |  | | | | | | | | | | | | | |

**Medical History**

**Surgical History**

**Social History**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Current Medications / Vitamins / Herbs / Supplements** *(list below or attach patient medication list)* | | | | | | | |
| **MEDICATION** | **START DATE** | **DOSAGE** | **FREQUENCY** | **MEDICATION** | **START DATE** | **DOSAGE** | **FREQUENCY** |
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| **Current Labs** | | | | | |
|  | **DATE** | **RESULT** |  | **DATE** | **RESULT** |
| HbA1C (current) |  |  | HbA1C (previous) |  |  |
| Total Cholesterol |  |  | Glucose |  |  |
| Triglycerides |  |  | GFR |  |  |
| HDL |  |  | TSH |  |  |
| LDL |  |  | Potassium |  |  |
| ALT |  |  | Proteinuria (Dipstick / Lab) |  |  |
| AST |  |  | Other |  |  |
| BUN |  |  | Radiology |  |  |
| Creatine |  |  |  |  |  |
| **Diagnoses: (current &/or differentials)**    **Use the space provided below to document additional pertinent data or abnormal lab values not indicated above.** | | | | | |
|  | | | | | |