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 |[x]  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**

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| **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.** |
|       |