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Project ECHO®

Endocrinology TeleECHO Clinic
Case Presentation Form

Complete ALL ITEMS on this form and fax to 505-272-6906.

***Required items in order to de-identify your case.**

1. Patient First Name*:	
2. Patient Last Name*:	
3. Patient Birthday*: (month/day/year)	
4. Patient Gender*:	
5. Clinic/Facility Name and City*:	
When do you want to present your case? Date and approximate time?	

PLEASE NOTE that Project ECHO® case consultations 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, we will email you with a confidential patient ID number (ECHO ID) that must be utilized when identifying your patient during clinic.

The information in this FAX message is privileged and confidential. It is intended only for the use of the recipient at the location above. If you have received this in error, any dissemination, distribution or copying of this communication is strictly prohibited. If you receive this message in error, please notify UNM Project ECHO at 505-925-2405 immediately.

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Endocrinology TeleECHO™ Clinic

— Diabetes (Adult) Case Presentation Template —

PLEASE NOTE that Project ECHO® case consultations 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.

Date: _______________ **Presenter Name:** ____________________________ **Clinic Site:** _________________

ECHO ID: __________ ☐ **New** ☐ **Follow Up** **Patient Age:** _______ **Biologic Gender:** ☐ Male or ☐ Female

Insurance: ☐ Medicaid/Centennial ☐ Medicare, ☐ Private, ☐ None **Insurance Company:**_______________

Race: ☐ American Indian/Alaskan Native, ☐ Asian, ☐ Black/African American, ☐ Native Hawaiian/Pacific Islander, ☐ White/Caucasian, ☐ Multi-racial, ☐ Other ________________________, ☐ Prefer not to say

Ethnicity: ☐ Hispanic/Latino, ☐ Not Hispanic/Latino, ☐ Prefer not to say

What is your main question about this patient? ☐ Behavioral Health, ☐ Adherence, ☐ Diet, ☐ Injection, ☐ Monitoring, ☐ Medications, ☐ Lab Interpretation, ☐ Resources ☐ Lifestyle (Activity), ☐ Other: ____

Endo (Diabetes – Adult)

☐ Type 1 Diabetes, ☐ Type 2 Diabetes Year of Diagnosis: _______ Years on Insulin:________

Family History of Diabetes? ☐ No ☐ Yes **Family History of Early CAD?** ☐ No ☐ Yes

Symptoms:

☐ Blurring Vision	☐ Burning/Numbing of Extremities	☐ Depression	☐ Increased Thirst/Urination
☐ Fatigue	☐ Weakness	☐ Weight Change Since Last Clinic Visit: ____________	☐ Other: _______________

PMHx:

☐ Diabetic Gastroparesis	☐ Diabetic Nephropathy	☐ Diabetic Neuropathy	☐ Diabetic Retinopathy
☐ Anxiety Disorder	☐ Bipolar Disorder	☐ Coronary Artery Disease	☐ Congestive Heart Failure
☐ Depression	☐ Eating Disorder	☐ Hyperlipidemia	☐ Hypertension
☐ Hypothyroidism	☐ Metabolic Syndrome	☐ Obesity	☐ Osteoarthritis
☐ Peripheral Vascular Disease	☐ Urinary Tract Infection	☐ Other_____________	

Hospitalizations: Dates of ED visits or hospitalizations since last clinic encounter: ___________, ____________

Psychiatric History:

Depression: PHQ9 Administered? ☐ No ☐ Yes – Score:_________ Date:__________ *Suicidality*: ☐ Yes ☐ No

Diagnosis & Treatment History:

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Substance Use History: *Does the patient have any history of substance use?* ☐ No ☐ Yes

Describe: ____
Does Patient Use Tobacco Products? ☐ No ☐ Yes – Number per day (1 pack = 20): ________________
Does Patient Drink Alcohol? ☐ No ☐ Yes – Number of drinks per week: __________________________

Medication Allergies: ____

Current Medications/Vitamins/Herbs/Supplements: Please feel free to attach your patient medication list.

Med Name	Dosage & Frequency	Med Name	Dosage & Frequency
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________

Insulin Pump: ☐ No ☐ Yes – Type: ________________________ (attach pump settings if available)

Continuous Glucose Monitor: ☐ No ☐ Yes – Type: ☐ Dexcom, ☐ Medtronic

Blood Glucose Monitoring: ☐ No ☐ Yes – Average Blood Glucose: ___________ Times Checked/Day: ______
Hypoglycemic episodes/week since last encounter: _______
Self-Reported Data? ☐ Yes ☐ No

CHW to Present

Social History:
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other: _________________
Literacy level of patient or caregiver: ☐ Limited ☐ Moderate ☐ Adequate

Household Members: ☐ Parents ☐ Grandparents ☐ Spouse/Partner ☐ Children ☐ Grandchildren ☐ Siblings
☐ Other: ____

Primary Source of Income: ☐ Full-time work, ☐ Part-time work, ☐ Pension/Retirement, ☐ SSI, ☐ Social Security
☐ Disability, ☐ SNAP/Food Stamps, ☐ Unemployment, ☐ VA Benefits, ☐ Social Security,
☐ TANF, ☐ WIC, ☐ No Income, ☐ Other:______________________________________

Social Support: ____

Patient Strengths:

Barriers to Treatment: Access to: ☐ Healthcare, ☐ Medication/Supplies, ☐ Transportation, ☐ Food, ☐ Housing,
☐ Social Support, ☐ Other Access Concerns: ______________________________________,
☐ Cultural Factors/Beliefs, ☐ Financial, ☐ Knowledge about Diabetes, ☐ Language,
☐ Other Barriers: ____

Patient Goals: ____

Healthcare Team's Primary Goals for Treatment: ____

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CHW to Present

24 Hour Diet Recall:

Meal and Description	Location of Meal	Portions	Snacks/Drinks b/w Meals
Breakfast:			**B/W Breakfast and Lunch**
Lunch:			**B/W Lunch and Dinner**
Dinner:			**After Dinner**

Exercise Activity: *Frequency of exercise (# of times/week):* _____________ *Average duration of exercise (minutes):* ____________ *Average intensity of exercise:* ☐ Low ☐ Moderate ☐ High

Interventions – What have you done so far?

Social Services Pathways: ☐Domestic Violence, ☐ Disability, ☐ Education/GED, ☐Employment, ☐ Food Security, ☐ Healthcare Insurance Access, ☐ Housing, ☐ Literacy Assistance, ☐ Medicine/Pharmacy Access, ☐ Transportation ☐ Other: ____

Medical Pathways: ☐ Alcohol Use, ☐ Blood Pressure, ☐ Blood Glucose Monitoring, ☐ Carbohydrate Counting, ☐ Cholesterol, ☐ Dental, ☐ Depression, ☐ Diet, ☐ Exercise, ☐ Explanation of Diabetes, ☐ Eye Health, ☐ Foot Health, ☐ High Blood Sugar, ☐ Label Reading, ☐ Low Blood Sugar, ☐ Medication Adherence Counseling, ☐ Sick Day Management, ☐ Lab Tests, ☐ Tobacco Use, ☐ Vaccines, ☐ Waist, Weight, BMI, ☐ Other: ____________________

Plan – What's your plan for this patient moving forward?

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Vitals:

Date: ________________ Systolic BP: _____________ Diastolic BP: ____________ Pulse: _________________

Height: ________________ Weight: ________________ ☐lbs. ☐ kgs. BMI: __________________

Physical Exam:

Foot Exam: ☐ Normal ☐ Abnormal *Funduscopic Exam:* ☐ Normal ☐ Abnormal

Pertinent Others: ____

Health Maintenance:

Immunizations: ☐ *Influenza* ☐ *Pneumococcal* ☐ *Hepatitis B* *Dental Exam:* Date:____________

Microvascular Screening Results

Dilated Eye Exam/Retinal Scan: Date: ____________ ☐ Normal ☐ Abnormal - ☐ Mild NPDR, ☐ Moderate NPDR, ☐ Severe NPDR, ☐ PDR

Comprehensive Foot Exam: Date: ____________ ☐ Normal ☐ Abnormal - ☐ Diminished Sensation ☐Diminished Pulses ☐Ulcer ☐ Wound ☐ Other: ________

Urine Albumin to Creatinine Ratio: Date: ______________ ☐ Normal ☐ Abnormal – UACR: _____________

Sexual Dysfunction Screening: Date: : ______________ ☐ Normal ☐ Abnormal__________________________

Current Labs:

HbA1C: Current _______, Previous________ ________ Total Chol: ___________ Triglycerides:_______

HDL: ________________ LDL: ____________________ ALT: ________________ AST: _______________

BUN: ________________ Creatinine: ______________ Glucose: _____________ GFR: _______________

TSH: ________________ Potassium: ______________ Proteinuria: _____________ (☐ Dipstick, ☐ Lab)

Other: ____

Other Comments: