



Extension for Community Healthcare Outcomes

Integrated Addictions & Psychiatry Clinic TeleECHO Clinic Case Presentation Form

Please complete the items on this form and fax to 505-272-6906.

* Patient First Name:	
* Patient Last Name:	
* Patient Birthday (MM/DD/YYYY):	
* Patient Gender:	
Patient Home Zip Code:	
Provider Phone Number:	
Provider Fax Number:	
Provider E-mail Address:	
* Clinic/Facility Name and City:	
When would you like to present your case? (date and approximate time)	

*** Required items.**

When we receive your case, we will e-mail you a confidential patient ID number (ECHO ID). Please use this ***new*** ID number to identify your patient during clinic.

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.

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Integrated Addiction & Psychiatry Clinic

— CASE PRESENTATION TEMPLATE —



PART I - GENERAL INFORMATION

Date: ___/___/___ Presenter: _____/_____ Clinical Site: _____
FIRST LAST

Patient Name: _____/_____ ECHO ID: _____
FIRST LAST

Age: _____ DOB: ___/___/___ Gender: Male or Female

Check One: New Case or Follow-up Molina patient? Yes No

Occupation: _____ Educational Level _____

WHAT IS YOUR MAIN QUESTION ABOUT THIS PATIENT?

Proposed treatment plan: _____

Medical problems/PMH (e.g.: cardiac status, pancreatitis, endocarditis, abscesses, liver disease):

Current medication: _____ N/A

Labs: N/A

Basic liver panel is needed prior to buprenorphine initiation, after 1 month of therapy and every 6 months while on treatment.

ALK Phos _____ Albumin _____ HIV _____

ALT _____ Total Protein _____ HCV _____

AST _____ BUN _____ HBV _____ Vaccinated _____

Bilirubin _____ Creatinine _____ HAV _____ Vaccinated _____

Pregnancy _____ TSH _____ H/H _____ Other _____

Physical exam: _____

Past drug treatment history (inpatient or outpatient, date, duration, past use of treatment meds, and duration of sobriety, self-help groups, withdrawal symptoms): N/A

Psychiatric history (symptoms/MSE, diagnoses, treatment, hospitalization, suicidality): _____

History of trauma (childhood physical, childhood sexual, domestic violence, adult sexual assault): _____

Psychiatric hospitalization: Yes No Number of times: _____

Past psychiatric medications: _____

Social history (legal/social consequences of drug use and/or psychiatric illness, employment, housing, education, relationships): _____

Family history (substance use, consequence of drug use and/or psychiatric illness): _____

PART II - GENERAL INFORMATION [skip to Part III if not applicable]

Chief complaint (check one): _____ N/A

Anxiety (non-PTSD, OCD) Depressed mood Psychosis Personality disorder

Symptoms of depression (check all that apply):

Sleep: increased decreased Appetite: increased decreased

Energy: increased decreased Anhedonia: present

Feelings: hopelessness helplessness guilty

How long symptoms? _____

Symptoms of panic (check all that apply):

palpitations sweating trembling chest pain shortness of breath

feeling of choking chills hot flashes dizziness derealization

fear of losing control fear of dying paresthesias GI symptoms

Panic symptoms predictability (check one): anticipated spontaneous

Constant worry (check one): present absent

How long symptoms: _____

Thoughts of suicide (check all that apply): passive active intent none

Plan _____
Past attempts? Yes No Number of times: _____ Method: _____
Delusions present? Yes No Hallucinations? Yes No Mania? Yes No

PART III - GENERAL INFORMATION

Substance use history:

Drug	Route	Frequency	Amount	Duration age of onset
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Stage of change (check one):

precontemplation contemplation preparation action maintenance

Patient's response to the following questions:

N/A

1. Why are you seeking help now?

2. What are your relapse triggers?

3. What are your sobriety supports?



Contact Person: Jill Gatwood, MPH, [505.272.8338](tel:505.272.8338) — jgatwood@salud.unm.edu
Melissa Meier, Coordinator Distance Education, 505.272.5811 —
mmmeier@salud.unm.edu

Phone: 505.750.ECHO (3246) • Fax: 505.272.6906 • Website: <http://echo.unm.edu> • E-mail: echo@salud.unm.edu