UNM HEALTH SCIENCES CENTER

Project ECHO®

Project ECHO® (Extension for Community Healthcare Outcomes)

Epilepsy TeleECHO™ Clinic

Please complete as many items as possible 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. Patient Home Zip Code:	
6. Provider Phone Number:	
7. Provider Fax Number:	
8. Provider Email:	
9. 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.

Clinician _____ Presentation Date _____

Clinical Site _____

Patient ECHO ID: _____ Is this your first time presenting this case? ☐ *(check if "yes")*

Gender: ☐ Male ☐ Female Age_____

WHAT IS YOUR MAIN QUESTION ABOUT THIS CASE?

[1] **Describe details of event** including postictal state: _____

_____

Approx. date of onset _____ Duration_____ Frequency_____

When do seizures occur? ☐ Wake ☐ Sleep ☐ Both ☐ Random Do seizures occur in clusters? ☐ Yes ☐ No

Are there provoking factors? ☐ Fever ☐ Sleep Deprivation ☐ Flashing Lights ☐ Menses ☐ Other (please explain):

_____

[2] **ETIOLOGY OF SEIZURES**

☐ Traumatic Brain Injury ☐ Brain Tumor ☐ Brain Infection ☐ Brain Abscess ☐ Stroke ☐ Cardiopulmonary Arrest

☐ Other *(if known):*_____

_____

[3] **WAS EEG PERFORMED?** ☐ Yes ☐ No ☐ Video EEG ☐ Regular EEG

RESULT: _____

[4] **IMAGING: CT?** ☐Yes ☐No Year Performed: _____ **RESULT:**_____

MRI? ☐Yes ☐No Year Performed: _____ **RESULT:**_____

MEDICATIONS:

Current daily medication(s)_____

_____

Prior seizure medication(s) _____

Recent anticonvulsive levels: _____

[5] **SIDE EFFECTS OF SEIZURE MEDICATION(S)** _____

[6] **HAS SURGICAL REFERRAL BEEN CONSIDERED?** ☐Yes ☐No

[7] **HAS COUNSELING ABOUT EPILEPSY SAFETY ISSUES BEEN OFFERED?** ☐ Yes ☐ No

☐ Driving ☐ Water Safety ☐ Other (explain) _____

PAST MEDICAL HISTORY

Pre/peri/postnatal complications:_____

_____

Hospitalizations: _____

_____

Chronic medical/psych conditions: _____

_____

Surgery: _____

_____

Injuries: _____

_____

GROWTH AND DEVELOPMENT:

☐ Normal ☐ Mild Delay ☐ Moderate Delay ☐ Severe Delay

Psychiatric diagnoses: ☐ ADHD Disorders: ☐ Learning ☐ Communication ☐ Mood ☐ Behavioral
☐ Bipolar Disorder ☐ Depression ☐ Anxiety ☐ Suicide Ideation ☐ Suicide Attempt ☐ Prior Institutionalization
☐ Schizophrenia ☐ Other *(if known):*_____

Cognitive issues: ☐ Attention ☐ Processing Speed ☐ Memory ☐ Executive Processing ☐ Intellectually Impaired

Neuropsych eval in past year? ☐ Yes ☐ No ☐ Unknown **Pertinent counseling provided?** ☐ Yes ☐ No ☐ Unknown

Child specific
Grade in school:_____Please check: ☐Regular Ed. ☐ Special Ed. Is the child passing in school? ☐Yes ☐ No
Is there a written Seizure Plan? ☐ Yes ☐ No Does School Nurse have Seizure Action Plan for this student? ☐ Yes ☐ No

PERTINENT FAMILY MEDICAL HISTORY:

☐Febrile Seizures ☐ Nonfebrile Seizures ☐ Neurological Disorders ☐ Sudden Death/Cardiac ☐ Unknown

SOCIAL HISTORY: Support System With whom does the patient live? _____
Substance Use: ☐ Yes ☐ No

REVIEW OF SYSTEMS *(PERTINENT POSITIVES)*:
EXAMINATION FINDINGS:
Height:_____ Weight_____kg
General Examination: _____
_____
_____
Neurologic Examination: _____
_____
_____
Alertness, ability to communicate and cooperate: _____

LABORATORY TESTING: (you may attach copies of reports)
Routine _____
Metabolic tests _____
Genetic tests _____

SYMPTOMS OF DEPRESSION AND/OR ANXIETY Yes ☐ No ☐
Please explain: Changes in ☐ Sleep ☐ Appetite ☐ Recreation ☐ Energy Level

[8] **FEMALES OF REPRODUCTIVE AGE:** Has reproductive counseling been offered? ☐ Yes ☐ No ☐ Unknown

The hyperscript numbers are national quality indicators (American Academy of Neurology, 2011)

1. Seizure type and current frequency
2. Etiology or epilepsy syndrome documented
3. EEG results reviewed, requested, or ordered
4. MRI reviewed, requested, or ordered (when appropriate)
5. Inquire about anti-seizure medication side effects
6. Surgical treatment referral considered for intractable epilepsy
7. Counseling about epilepsy specific safety issues
8. Counseling for women of childbearing potential with epilepsy