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.

Endocrinology TeleECHO™ Clinic

— PCOS/HIRSUTISM PRESENTATION TEMPLATE —

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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

Diagnosis: ☐ Polycystic Ovary Syndrome (PCOS) ☐ Hirsutism without PCOS **Date of Diagnosis:** _____

Symptoms:

☐ Abnormal Menses	☐ Acne	☐ Easy Bruising	☐ Galactorrhea
☐ Hair Loss	☐ Headaches	☐ Hirsutism	☐ Infertility
☐ Mood Changes	☐ Muscle Weakness	☐ Visual Disturbances	☐ Weight Change: _____ ☐lbs. ☐ kgs.

☐ Other: _____

Past Medical History:

☐ Dyslipidemia	☐ Gestational Diabetes	☐ Gravida/Para: _____	☐ Hypertension
☐ Obesity	☐ Osteoarthritis	☐ Type 1 Diabetes	☐ Type 2 Diabetes

☐ Other: _____

Psychiatric History

Depression: PHQ9: _____ Date:_____

Medication Allergies: _____

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

Med Name	Dosage & Frequency	Med Name	Dosage & Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History:

☐ Breast Cancer ☐ Diabetes ☐ Ovarian Cancer

Smoking History: *Does patient currently smoke?* ☐ No ☐ Yes – Number of cigarettes per day (1 pack = 20): _____

Alcohol Consumption: *Does patient currently drink?* – ☐ No ☐ Yes – Number of drinks per week: _____

Please send to: Endo ECHO Clinic Coordinator — endoecho@salud.unm.edu
Phone: (505) 925-0904 • Fax: (505) 272-6906

Vitals:

Date: _____ Systolic BP: _____ Diastolic BP: _____ Pulse: _____
Height: _____ Weight: _____ ☐lbs. ☐ kgs. BMI: _____

Physical Exam:

☐ Abnormal Thyroid: _____

☐ Acanthosis ☐ Acne ☐ Cervicodorsal Hump ☐ Facial Plethora

☐ Hirsutism ☐ Male Pattern Baldness ☐ Moon Facies ☐ Proximal Muscle Weakness

☐ Violaceous Striae ☐ Other: _____

Current Labs:

Estradiol: _____ pg/mL Total Testosterone: _____ ng/mL
Free Testosterone: _____ ng/dL TSH: _____ uIU/mL
Prolactin: _____ ng/mL Hemoglobin A1c: _____ %
24 Hr. Urine Free Cortisol: _____ mcg/24 hrs. DHEA – Sulfate: _____ mcg/dL
17 Hydroxyprogesterone: _____ ng/dL

Pertinent Imaging Studies:

☐ Pelvic Ultrasound Date: _____ ☐ Normal ☐ Abnormal: _____
☐ Other: _____

Other Comments: