

Extension for Community Healthcare Outcomes
**Primary Care TeleECHO™ Clinic Case
Presentation Form**

Complete ALL ITEMS on this form and fax to **505-272-6906, Attn: Primary Care TeleECHO Clinic**

1. Patient First Name:	
2. Patient Last Name:	
3. Patient Birthday: (month/day/year)	
4. Patient Home Zip Code:	
5. Presenter Phone Number:	
6. Presenter Fax Number:	
7. Presenter Email:	
8. Clinic/Facility Name and City:	
9. 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, an email will be sent 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 Project ECHO at 505-750-3246 immediately.

Primary Care TeleECHO Clinic

— PATIENT CASE PRESENTATION —

Molina Patient? Yes

No

New Case

Follow Up

Presenter _____ Clinical Site _____

ECHO ID # _____ Age _____ Gender: M F BMI _____

Ethnicity: Hispanic/Latino; 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?

Current Medications/Vitamins/Herbs/Supplements (List below or attach patient medication list)

Medication	Start Date	Dosage	Frequency	Medication	Start Date	Dosage	Frequency

Presenting Symptoms

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Physical Findings

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Current Labs (List below with date or attach labs)

	Date	Result		Date	Result
HbA1C (current)			HbA1C (previous)		
Total Cholesterol			Glucose		
Triglycerides			GFR		
HDL			TSH		
LDL			Potassium		
ALT			Proteinuria (<input type="checkbox"/> Dipstick/ <input type="checkbox"/> Lab)		
AST			Other		
BUN			Radiology		
Creatinine					

Use the box below to document additional data or abnormal lab values not indicated above.