UNM HEALTH SCIENCES CENTER

Project ECHO®

Project ECHO® Extension for Community Healthcare
***Outcomes* Miners' Wellness**

TeleECHO™ Clinic Case Presentation Form

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

1. Patient First Name*:	
2. Patient Last Name*:	
3. Patient Birthday*: (MM/DD/YYYY)	
4. Patient Home Zip Code:	
5. Provider Name:	
6. Provider Phone Number:	
7. Provider Fax Number:	
8. Provider Email:	
9. Provider Clinic/Facility Name, City and State*:	
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.

***Required items. 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 the teleECHO clinic.**

ECHO ID, if known: _____ ☐New Case ☐Follow-up Case

PLEASE CHECK ALL BOXES RELEVANT TO THE MANAGEMENT QUESTIONS

By presenting this case, I hope to obtain -

☐Help with diagnosis ☐Help with clinical management ☐Help with test quality/interpretation
☐Help with legal/benefits counseling ☐ Other –please state

Patient demographic information

☐Male ☐Female
Age (in years) _____
State of primary current residence
☐NM ☐ WY ☐UT ☐MT ☐ Other_____

Smoking history

☐Current smoker ☐Former smoker ☐Never smoked
If applicable, cumulative pack-years of smoking_____

Occupational History

Please check details of mining/milling/transportation exposure

Coal	**Uranium**	**Metal or Non-metal (including sand, gravel, quarry workers, and others)** **Type of metal or non-metal exposure: _____**
Duration of exposure in years: _____ **Year of start of exposure: _____;** **Year of end of exposure__**	**Duration of exposure in years: _____** **Year of start of exposure: _____;** **Year of end of exposure__**	**Duration of exposure in years: _____** **Year of start of exposure: _____;** **Year of end of exposure__**
Sites: ☐Underground mine ☐Above ground mine ☐Mills ☐Transportation related to mine/mill ☐Multiple sites of exposure	**Sites:** ☐Underground mine ☐Above ground mine ☐Mills ☐Transportation related to mine/mill ☐Multiple sites of exposure	**Sites:** ☐Underground mine ☐Above ground mine ☐Mills ☐Transportation related to mine/mill ☐Multiple sites of exposure

Medical History and Examination

Please check symptoms, if applicable

Symptom	Yes (Y) or No (N)	If yes, year of onset (yyyy) or age of onset (in yrs.)	Comment, if applicable
Dyspnea on exertion			
Dyspnea at rest			
Cough			
Phlegm			
Wheeze			
Other			

Please check if the patient has a clinical provider-given diagnosis for the following, if applicable

Symptom	Yes (Y) or No (N)	If yes, year of onset (yyyy) or age of onset (in yrs.)	Comment, if applicable
COPD-emphysema phenotype			
COPD-chronic bronchitis phenotype			
Pulmonary fibrosis			
Pneumoconiosis/Silicosis			
Secondary pulmonary hypertension/cor pulmonale			
Asthma			
Other			

Please describe the following examination findings

Date of examination _____

Height (inches)_____ Weight(lbs.) _____BMI (kg/m2) _____

Lung auscultation findings_____

Pedal edema_____

Clinical Tests

Please check if the patient has had any of the following tests, if applicable

**** You may attach test results if you wish, but please black out any personally identifying information.***

Test	Date of test (MM/DD/YYYY)	Absolute value and/or % predicted	Comment on Quality
Prebronchodilator spirometry			
Postbronchodilator spirometry			
Lung volume			
Diffusing capacity			
Arterial blood gas at rest			
Arterial blood gas with activity			
Chest radiograph			
B-read of chest radiograph			
Other			

***If serial spirometry tests are available, please summarize the relevant ones below.**

Date of test (MM/DD/YYYY)	Weight in pounds	Prebronchodilator FVC (Ls. and % predicted)	Prebronchodilator FEV1(Ls. and % predicted)	FEV1/FVC ratio

* ***You may attach test results if you wish, but please black out any personally identifying information.***

Please check if the patient has applied for any of the following benefits

	Does this patient's history and clinical tests qualify him/her for this benefit? Yes/No	**Has patient applied for this benefit? Yes/No**	**Has patient been approved for this benefit? Yes/No**	**Comment, if applicable**
Uranium workers- Energy Employment Occupational Illness Compensation Program				
Coal workers -Black Lung Benefits Act				
Social Security Disability				
Workers' Compensation/Others				

Clinical and non-Clinical Management Questions

1. _____
2. _____
3. _____
4. _____

* ***You may attach medication lists/chart notes, but please black out any personally identifying information.***
By initialing here _____ you have understood 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.