Please note that Project ECHO® case consultations do not create or otherwise establish a provider-patient relationship between any Wyoming Geriatric ECHO clinician and any patient whose case is being presented in a Project ECHO® setting.

Complete all items on this form and fax to (307) 766-2763 or email to wycoa@uwyo.edu.

*When we receive your case, we will email or fax you a confidential patient ID number (ECHO ID) that must be utilized when identifying your patient during clinic.

**Echo ID Number:**

**Date:** ________________

**What is the main question about this person you want help with?**

<table>
<thead>
<tr>
<th>Individual’s Information:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New Presentation</strong></td>
<td><strong>Follow Up</strong></td>
</tr>
<tr>
<td>Person’s Age:</td>
<td></td>
</tr>
<tr>
<td>Person’s Gender:</td>
<td></td>
</tr>
</tbody>
</table>

**Presenting Spoke Site Information:**

| Organization Name & Location: |  |
| Organization contact/email: |  |
| Presenter Name/title/Credentials: |  |
MEDICAL HISTORY

Fill in specifics if applicable:

List of medical problems/diagnoses (can attach documentation):

_____________________________________________________________________________________

Brief History of Present Illness (may attach a recent clinic progress note):

_____________________________________________________________________________________

LIFE HISTORY:

- Current Living Situation

_____________________________________________________________________________________

PAST LIFE ACTIVITIES/INTERESTS

- Patient current/previous occupation

_____________________________________________________________________________________

- Patient Educational Level

_____________________________________________________________________________________

- Life Interests (hobbies, skills, talents):

_____________________________________________________________________________________

Advance care plan on file? ☐ Yes ☐ No. Details:

_____________________________________________________________________________________

Family Conference Documented? ☐ Yes ☐ No. Details

_____________________________________________________________________________________

History of falls? Yes No. Injury? ☐ Yes ☐ No. Please describe:

_____________________________________________________________________________________

Current meds and therapies (may attach a list):

_____________________________________________________________________________________

Meds and therapies that have been tried in the past:

_____________________________________________________________________________________

Check all that apply:

☐ Needs help with Activities of Daily Living (ADLs) specify:

_____________________________________________________________________________________

☐ Needs help with Instrumental Activities of Daily Living (iADLs) specify:

_____________________________________________________________________________________

☐ Current Problem Behaviors (e.g. Agitation, aggression, resistance to care, inappropriate behavior):

_____________________________________________________________________________________

☐ Substance use history (Circle): ETOH Opioids Nicotine Caffeine Cannabis NONE Other:

_____________________________________________________________________________________

☐ Pain? ☐ Yes ☐ No. Details

_____________________________________________________________________________________

☐ Sleep Problem? ☐ Yes ☐ No. Details

_____________________________________________________________________________________

☐ Other?

_____________________________________________________________________________________

Page 2 of 3
**REVIEW OF SYSTEMS**

Please check all that apply:

- [ ] Wandering
- [ ] Constipation
- [ ] Incontinence
- [ ] Anxiety
- [ ] Hearing Loss
- [ ] Depression
- [ ] Vision Impairment
- [ ] Other(s):

**Physical Exam- Pertinent Findings:**

**Cognitive Screening Exam: Please attach findings if available**

- [ ] SLUMS  
  Notes:______________________________________________________________
- [ ] MMSE  
  Notes:______________________________________________________________
- [ ] MoCA  
  Notes:______________________________________________________________
  MoCA©) is available from [http://www.parkinsons.va.gov/consortium/moca.asp](http://www.parkinsons.va.gov/consortium/moca.asp)
- [ ] MINI-COG  
  Notes:______________________________________________________________

**Neuropsychology Testing (may attach a report):**

**Pertinent Labs and Imaging (may attach a report):**

**Person's Decision Making Capacity:**  
- [ ] Decisional
- [ ] Not Decisional
- [ ] Not Sure
- [ ] Other: ____________________For non-decisional patient: decisions are made by: ____________________

**Financial Concerns:**  
- [ ] No
- [ ] Not Sure
- [ ] Yes ____________________

**Goals of Care: (What is important to the person/family?)** ____________________

**Any other information that you think is important:** ____________________

**REMINDER:** You will have 20 minutes to present your case to the echo, and this case form/additional materials will be given to those on the network to review ahead of time. When presenting be brief to allow discussion.

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Contact Person: Catherine Carrico, PhD  •  (307) 766-6687  •  ccarrico@uwyo.edu  •  Fax: (307) 766-2763