**UW ECHO® in Geriatrics Network**
University of Wyoming
WyCOA ECHO Clinics
Phone (307) 766-2829 | Fax (307) 766-2763

# UW ECHO® in Geriatrics Network Case Presentation Form

*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 YOUR MAIN QUESTION ABOUT THIS PATIENT?

_____

_____

| Patient Information: | |
|---|---|
| **New Patient** ☐ **Follow Up** ☐ **(Case #:_____)** | |
| **Patient Age:** | |
| **Patient Gender:** | |
| Presenting Spoke Site Information: | |
| **Organization Name & Location:** | |
| **Organization contact/email:** | |
| **Presenter Name/title**: | |

## PATIENT MEDICAL HISTORY

**Check all that apply and fill in specifics if applicable:**

- ☐ Dementia _____
- ☐ DM2 _____
- ☐ HTN _____
- ☐ CVA _____
- ☐ Delirium _____
- ☐ Depression _____
- ☐ Anxiety _____
- ☐ Bipolar _____
- ☐ Schizophrenia _____
- ☐ Parkinsonism _____
- ☐ SUBSTANCE ABUSE HISTORY (Circle): ETOH Opioids Nicotine Caffeine Cannabis Other:_____

SOCIAL HISTORY:

- ☐ Alone in home/apt _____
- ☐ Nursing Home _____
- ☐ Assisted Living _____
- ☐ With spouse, family or friend _____
- ☐ Patient current/previous occupation _____
- ☐ Patient Educational Level _____

- ☐ Issues of Activities of Daily Living (ADLs) _____
- ☐ Issues of Instrumental Activities of Daily Living (iADLs) _____
- ☐ Determining the patient's diagnosis _____
- ☐ Agitation and/or aggression _____
- ☐ Advance care planning _____
- ☐ Inappropriate behavior _____
- ☐ Other(s) _____

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

**Psychiatric hospitalization:** ☐ Yes ☐ No Number of times: _____

**Current meds and therapies** (may attach a list): _____

**Meds and therapies that have been tried in the past:** _____

**History of Falls?** ☐Yes ☐No Please describe: _____

## REVIEW OF SYSTEMS

**Please check all that apply:**

☐Insomnia ☐ Wandering ☐ Constipation ☐ Incontinence ☐ Anxiety ☐ Pain ☐ Hearing Loss

☐ Agitation ☐Depression ☐Drowsiness ☐ Vision Impairment ☐Other(s):

**Physical Exam-** Pertinent Findings:

**Cognitive Screening Exam: Please attach findings**

☐ SLUMS Notes:_____

☐ MMSE Notes:_____

☐ MoCA Notes:_____

MoCA©) is available from 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):

**Patient'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 patient/family?)** _____

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

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