**UW ECHO® in Geriatrics Network Case Presentation Form**

**PLEASE NOTE** that Project ECHO® case consultations do not create or otherwise establish a provider-case relationship between any UW ECHO in Geriatrics clinician and any person 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 Network ID number (ECHO ID) that must be utilized when identifying your person/case during clinic.*

<table>
<thead>
<tr>
<th>ECHO ID Number:</th>
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</thead>
<tbody>
<tr>
<td>Date: __________</td>
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</table>

**WHAT IS THE MAIN QUESTION ABOUT THIS PERSON YOU WANT HELP WITH?**

<table>
<thead>
<tr>
<th>Individual’s Information:</th>
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</thead>
<tbody>
<tr>
<td>New Presentation ☐ Follow Up ☐ (Case #:_______)</td>
</tr>
<tr>
<td>Person’s Age:</td>
</tr>
<tr>
<td>Person’s Gender:</td>
</tr>
</tbody>
</table>

**Presenting Spoke Site Information:**

<table>
<thead>
<tr>
<th>Organization Name &amp; Location:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization contact/email:</td>
</tr>
<tr>
<td>Presenter Name/title/Credentials:</td>
</tr>
</tbody>
</table>
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
➢ Current/previous occupation _______________________________________________________
➢ 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 medications and therapies (may attach a list): ______________________________________
Medications 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? ____________________________________________________________
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

☐ 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 person: 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: ________________________________________________________________________________

REMARKER: 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