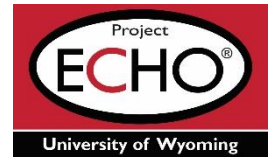




UW ECHO® in Geriatrics Network
 University of Wyoming
[WyCOA ECHO Clinics](#)
 Phone (307) 766-2829 | Fax (307) 766-2763



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 <input type="checkbox"/> Follow Up <input type="checkbox"/> (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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