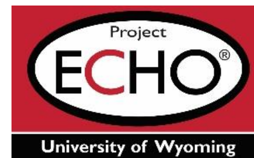
UW ECHO® in Geriatrics Network
University of Wyoming
WyCOA ECHO Clinics
Phone (307) 766-2829 | Fax (307) 766-2847



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) 766-2847 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.

Date: ____________________ Case ID: _________________________

Case Presenter Name/Credentials, Organization, and Contact Info: __________________________________

____

Case Information: Age: _______ Gender: _______ New Case (Y/N):______ Follow-up Case? (Y/N) ____ID #____

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

Please check all that apply:

- ☐ Symptom Management (Insomnia, paranoia, hallucinations wandering, anxiety, etc.)
- ☐ Advanced Care Planning
- ☐ Incontinence
- ☐ Constipation
- ☐ Determining the persons diagnosis
- ☐ Agitation and/or aggression
- ☐ Depression
- ☐ Inappropriate Behavior
- ☐ Dementia Specific Treatment options
- ☐ Issues of ADLs and iADLs
- ☐ Sensory loss
- ☐ Pain
- ☐ Sleep Problems
- ☐ Other: ______________________________

Additional information as related to your main question:

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):

____

____

What Matters: Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care. Please provide any of the following information you have at this time.

GOALS OF CARE/PAST LIFE ACTIVITIES/INTERESTS:

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

  ____

  ____

- Goals of Care (What is important to the Care Team?):

  ____

  ____

- Current Living Situation: ____
- Current/previous occupation: ____
- Educational Level: ____
- Life Interests (hobbies, skills, talents):____

  ____

- Spiritual/Religious Resources: ____
- Advance care plan on file? Yes ___ No ___. Details: ___________________________________
- Family Conference Documented? Yes ___ No ___. Details_______________________________

  ____

- Financial Concerns? Yes ___ No ___ Not Sure ___. Details: _____________________________

Medication: If medication is necessary, use age-friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care. Please provide any of the following information you have at this time.

Current medications and therapies (may attach a list): ___________________________________

____

Medications and therapies that have been tried in the past: ______________________________

____

<u>Mentation</u>: Prevent, identify, treat, and manage dementia, delirium, and depression across settings of care. Please provide any of the following information you have at this time.

Cognitive Screening Exam: Please attach findings if available

- SLUMS. Notes:____
- MMSE. Notes:____
- MoCA. Notes:____
- 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____

*For a non-decisional person, decisions are made by: __________________________________

- Current Problem Behaviors (e.g. Agitation, aggression, resistance to care, inappropriate behavior): _____________
  ____
- Substance use history (Circle): ETOH Opioids Nicotine Caffeine Cannabis NONE
  Other:____
- Other: ____

<u>Mobility:</u> Ensure that each older adult moves safely every day to maintain function and do What Matters. Please provide any of the following information you have at this time.

- History of falls? Yes ___ No ___ Injury? Yes ___ No ___. Please describe: ______________________________
  ____
- Please describe any issues with mobility and any adaptive equipment or measures: ______________________
  ____

REMINDER: You will have 20 minutes to present your case to the ECHO, and this case form/additional materials will be given to the Hub Team to review ahead of time. When presenting be brief to allow discussion.

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