Project ECHO® (Extension for Community Healthcare Outcomes)

SUD/ Harm Reduction in the Community- Initial Case Presentation Form

Presentation Date:________________Site:____________________________Clinician:______________________________

General Information/Demographics

Patient ECHO ID: please use clinician last name and case study (e.g. Wang1)	**Age:**	**Sex at Birth:** ☐Male ☐Female	**Gender Identity:**
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian / Other Pacific Islander ☐ White			**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Insurance: ☐ None ☐ Medicare ☐ Medicaid ☐ Commercial Health Insurance ☐ Other:______________________________

Social history: Housing? ___________Employment/ Disabled? _______________ Other pertinent details: (i.e. incarcerated/ legally involved?)

HPI- Please list any additional pertinent information about the patient: (No identifying factors please: presenting symptoms, pain, physical findings, sleep, appetite, functional status etc.)

Nicotine Dependence? ☐ Yes ☐No E-cig use? ☐ Yes ☐No

Psychiatric Diagnoses	☐ Depression ☐ Anxiety ☐ Schizophrenia ☐ Other: **History of hospital admission for BH?** ☐ Yes ☐No **Number of times:**_________ **History of Suicide Attempt?** ☐ Yes ☐No **Method/ year:**____________/_______
MH/BH Screening & Assessment	☐ PHQ 2/9:___________ ☐ GAD 7:__________ ☐ Other:____________ ☐ Mental Status Exam:

Appearance:	Mood:	Memory:
Behavior:	Affect:	Attention:
Motor:	Thought Process:	Insight:
Speech:	Thought Content:	Judgement:

Substance Use History	Does the person have a substance use disorder? ☐ Yes ☐No	
	If yes, ☐Alcohol ☐Opiates ☐Stimulants ☐Benzodiazepines ☐Marijuana ☐Other: If yes, date of last use (for each):	
	History of injecting drugs? ☐Yes ☐No Does patient utilize syringe exchange program **(SEP)?** ☐ Yes ☐No **Narcan Access?** ☐ Yes ☐No	If yes, Drug of choice & date of last injection drug use: ________________/_____________

Body Mass Index	Height:	Weight:	BMI:

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Medical Diagnoses	☐ Diabetes Mellitus ☐ Dyslipidemia ☐ HIV ☐ HCV	☐ Hepatitis B, Chronic ☐ Seizure Disorder ☐ Traumatic Brain Injury ☐ Other Relevant Diagnoses:

Current Medications/ Supplements:

Medication Name	Dosage	Frequency

Previously Treatments Tried (i.e. detox, residential, meds)

Current Method of Birth Control:________________________ Allergies: _______________________________________

Laboratory

Basic Labs	Date	Results
WBC		
HGB		
HCT		
Platelets		
Creatinine		
GFR		
Glucose/ A1C		
Protime/INR		

Basic Labs	Date	Results
Total Prot		
Albumin		
Alk Phos		
AST		
ALT		
T. Bili		
Direct Bili		
Lipids		

Other Labs	Date	Results
Vitamin D		
Fe		
TIBC		
Ferritin		
AFP		
HIV Ab		
HCV RNA		
HCV Genotype		

Other Pertinent Labs / Urine Drug Screen Results:	**Date**	**Results**

Hepatitis Vaccinations and Labs		
	Hepatitis A total or IgG antibody: ☐Positive ☐Negative	If needed has vaccination been started? ☐Yes ☐No
	Hepatitis B surface antibody (anti-HBs): ☐Positive ☐Negative Hepatitis B core antibody (anti-HBc): ☐Positive ☐Negative Hepatitis B surface antigen (HBsAg): ☐Positive ☐Negative	If needed has vaccination been started? ☐Yes ☐No

Other pertinent imaging or diagnostics?

What is the primary question you have regarding this patient?

PLEASE NOTE that case consultations do not create or otherwise establish a provider-patient relationship between any clinician and any patient whose case is being presented in this clinical setting. Always use Patient ID# when presenting a patient in clinic. Sharing patient name, initials or other identifying information violates HIPAA privacy laws.

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