UNM HEALTH SCIENCES CENTER

Project ECHO®

Endocrinology TeleECHO™ Clinic
Case Presentation Form

Complete ALL ITEMS on this form and fax to 505-272-6906.

***Required items in order to de-identify your case.**

1. Patient First Name*:	
2. Patient Last Name*:	
3. Patient Birthday*: (month/day/year)	
4. Patient Gender*:	
5. Patient Home Zip Code:	
6. Provider Phone Number:	
7. Provider Fax Number:	
8. Provider Email:	
9. Clinic/Facility Name and City*:	
When do you want to present your case? Date and approximate time?	

PLEASE NOTE that Project ECHO® case consultations do not create or otherwise establish a provider-patient relationship between any UNMHSC clinician and any patient whose case is being presented in a Project ECHO® setting.

When we receive your case, we will email you with a confidential patient ID number (ECHO ID) that must be utilized when identifying your patient during clinic.

The information in this FAX message is privileged and confidential. It is intended only for the use of the recipient at the location above. If you have received this in error, any dissemination, distribution or copying of this communication is strictly prohibited. If you receive this message in error, please notify Project ECHO® at 505-925-2405 immediately.

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Endocrinology TeleECHO™ Clinic

— Diabetes (Adult) Case Presentation Template —

PLEASE NOTE that Project ECHO® case consultations do not create or otherwise establish a provider-patient relationship between any UNMHSC clinician and any patient whose case is being presented in a Project ECHO® setting.

Outlined items may be filled out by Community Health Worker if available

Date: ______________ **Presenter Name:** ___________________________ **Clinic Site:** ________________

ECHO ID: __________ ☐ **New** ☐ **Follow Up** **Patient Age:** ______ **Biologic Gender:** ☐ Male or ☐ Female

Insurance: ☐ Medicaid/Centennial ☐ Medicare, ☐ Private, ☐ None **Insurance Company:**________________

What is your main question about this patient? ☐ Behavioral Health ☐ Compliance/Adherence ☐ Diet ☐ Injection ☐ Monitoring ☐ Medications Oral ☐ Lab Interpretation ☐ Resources ☐ Lifestyle (Activity) ☐ Other: ____

Race: ☐ American Indian/Alaskan Native, ☐ Asian, ☐ Black/African American, ☐ Native Hawaiian/Pacific Islander, ☐ White/Caucasian, ☐ Multi-racial, ☐ Other _______________________, ☐ Prefer not to say

Ethnicity: ☐ Hispanic/Latino, ☐ Not Hispanic/Latino, ☐ Prefer not to say

Endo (Diabetes – Adult)

☐ Type 1 Diabetes, ☐ Type 2 Diabetes Year of Diagnosis: _______ Years on Insulin:________

Symptoms:

☐ Blurring Vision	☐ Burning/Numbing of Extremities	☐ Depression	☐ Increased Thirst/Urination
☐ Fatigue	☐ Weakness	☐ Weight Change Since Last Clinic Visit: ___________	☐ Other: _______________

PMHx:

☐ Diabetic Gastroparesis	☐ Diabetic Nephropathy	☐ Diabetic Neuropathy	☐ Diabetic Retinopathy
☐ Anxiety Disorder	☐ Bipolar Disorder	☐ Coronary Artery Disease	☐ Congestive Heart Failure
☐ Depression	☐ Eating Disorder	☐ Hyperlipidemia	☐ Hypertension
☐ Hypothyroidism	☐ Metabolic Syndrome	☐ Obesity	☐ Osteoarthritis
☐ Peripheral Vascular Disease	☐ Urinary Tract Infection	☐ Other____________	

Psychiatric History:

Depression: PHQ9: _______ Date:_______

http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf

Diagnosis & Treatment History: ____

Hospitalizations: Dates of ED visits or hospitalizations since last clinic encounter: ___________, ____________

Please fax to: Leena Matlib – Clinic Coordinator — leena23@salud.unm.edu
Phone: (505) 925-2405 • Fax: (505)-272-6906

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Insulin Pump: ☐ No ☐ Yes – Type: ____________

Basal Rate (s)		Insulin to Carb Ratio		Insulin Sens. Factor		Blood Glucose Target	
Time of day	Units/hour	Time of day	Ratio	Time of day	Number	Time of day	Mg/dL
________	________	________	________	________	________	________	________
________	________	________	________	________	________	________	________
________	________	________	________	________	________	________	________

Active Insulin Time (hours): ________ Total Basal Dose (units): _________ Average Total Daily Dose (units): ________

Continuous Glucose Monitor: ☐ No ☐ Yes – Type: ☐ Dexcom, ☐ Medtronic

Blood Glucose Monitoring: ☐ No ☐ Yes – Average Blood Glucose: ___________ Times Checked/Day: ______

Hypoglycemic episodes/week since last encounter: _______

Glucometer Download:

Average number of blood glucose checks per day: ______ *Average blood glucose:* ______

Standard Deviation: _______ *Number of blood glucose readings less than 70:* __________

Medication Allergies: ____

Current Medications/Vitamins/Herbs/Supplements: Please feel free to attach your patient medication list

Med Name	Dosage & Frequency	Med Name	Dosage & Frequency	Med Name	Dosage & Frequency
______________	_________	______________	_________	______________	_________
______________	_________	______________	_________	______________	_________
______________	_________	______________	_________	______________	_________
______________	_________	______________	_________	______________	_________
______________	_________	______________	_________	______________	_________

Adherence to Treatment:

Number of missed insulin doses/week since last encounter: Basal: _______ Bolus: _________

Counseling by CHW – ☐ *No,* ☐ *Yes (ineffective),* ☐ *Yes (effective)*

Motivation/readiness for change: ☐ 1, ☐ 2, ☐ 3, ☐ 4, ☐ 5, ☐ 6, ☐ 7, ☐ 8, ☐ 9, ☐ 10

Substance Use History: *Does the patient have any history of substance use?* ☐ No ☐ Yes

Describe: ____

Substance	*Typical Usage Pattern*	*Last Use Date*
Prescription Opiate Misuse:	______________________________	__________
Cannabis:	______________________________	__________
Cocaine:	______________________________	__________
Benzodiazepines/Sedatives:	______________________________	__________
Heroin:	______________________________	__________
Other: ___________:	______________________________	__________

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CHW to Present

Social History:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other: _______________

Literacy level of patient or caregiver: ☐ Limited ☐ Moderate ☐ Adequate

http://www.pfizer.com/files/health/nvs_flipbook_english_final.pdf

Patient Strengths: ____

____

Barriers to Treatment: ☐ Access to Care, ☐ Attitudes & Beliefs, ☐ Cultural Factors, ☐ Financial, ☐ Knowledge about Diabetes, ☐ Language, ☐ Psychosocial, ☐ Transportation, ☐ Other: ____________________

Smoking History: *Does patient currently smoke*? ☐ No ☐ Yes – Number per day (1 pack = 20): __________

Counseling by CHW – ☐ *No,* ☐ *Yes (ineffective),* ☐ *Yes (effective)*

Motivation/readiness for change: ☐ 1, ☐ 2, ☐ 3, ☐ 4, ☐ 5, ☐ 6, ☐ 7, ☐ 8, ☐ 9, ☐ 10

Alcohol Consumption: *Does patient currently drink*? ☐ No ☐ Yes – Number per week: __________

Counseling by CHW – ☐ *No,* ☐ *Yes (ineffective),* ☐ *Yes (effective)*

Motivation/readiness for change: ☐ 1, ☐ 2, ☐ 3, ☐ 4, ☐ 5, ☐ 6, ☐ 7, ☐ 8, ☐ 9, ☐ 10

Diet: *Meals per day:* _______ *Snacks per day:* _______ *Carb-containing beverages per day:* _______

Meals per week outside the home: _______ Servings of fruit per day: ________

Average carbohydrate content (grams): Breakfast: ________ Lunch: ________ Dinner: ________

Counseling by CHW – ☐ *No,* ☐ *Yes (ineffective),* ☐ *Yes (effective)*

Motivation/readiness for change: ☐ 1, ☐ 2, ☐ 3, ☐ 4, ☐ 5, ☐ 6, ☐ 7, ☐ 8, ☐ 9, ☐ 10

Exercise Activity: *Frequency of exercise (# of times/week):* ____________ *Average duration of exercise (minutes):* ____________ *Average intensity of exercise:* ☐ Low ☐ Moderate ☐ High

Counseling by CHW – ☐ *No,* ☐ *Yes (ineffective),* ☐ *Yes (effective)*

Motivation/readiness for change: ☐ 1, ☐ 2, ☐ 3, ☐ 4, ☐ 5, ☐ 6, ☐ 7, ☐ 8, ☐ 9, ☐ 10

Family History of Diabetes? ☐ No ☐ Yes **Family History of Early CAD?** ☐ No ☐ Yes

Health Maintenance:

Dilated Eye Exam/Retinal Scan: Date:__________ *Foot Exam:* Date:___________

Immunizations: ☐ *Influenza* ☐ *Pneumococcal* ☐ *Hepatitis B* *Dental Exam:* Date:___________

Vitals:

Date: _______________ Systolic BP: ____________ Diastolic BP: ___________ Pulse: _____________

Height: _______________ Weight: _______________ ☐lbs. ☐ kgs. BMI: _____________

Physical Exam:

Foot Exam: ☐ Normal ☐ Abnormal *Funduscopic Exam:* ☐ Normal ☐ Abnormal

Pertinent Others: ____

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Microvascular Screening Results

Dilated Eye Exam/Retinal Scan: Date: ____________ ☐ Normal ☐ Abnormal - ☐ Mild NPDR, ☐ Moderate NPDR, ☐ Severe NPDR, ☐ PDR

Comprehensive Foot Exam: Date: ____________ ☐ Normal ☐ Abnormal - ☐ Diminished Sensation ☐Diminished Pulses ☐Ulcer ☐ Wound ☐ Other: ________

Urine Albumin to Creatinine Ratio: Date: ______________ ☐ Normal ☐ Abnormal – UACR: _____________

Current Labs:

HbA1C: Current _______, Previous________ ________ Non HDL: ___________ Triglycerides:_______

HDL: ________________ LDL: ____________________ ALT: ________________ AST: _______________

BUN: ________________ Creatinine: ______________ Glucose: _____________ GFR: _______________

TSH: ________________ Potassium: ______________ Proteinuria: _____________ (☐ Dipstick, ☐ Lab)

Other: ____

Other Comments: