Endocrinology TeleECHO Clinic
Case Presentation Form

Complete ALL ITEMS on this form and fax to 503.228.4801

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 a clinic. Sharing patient name, initials or other identifying information violates HIPAA privacy laws.***

1. Patient Age:	
2. Patient Gender:	Male Female Trans Male Trans Female Gender Queer / Gender Non-Conforming
3. Clinic/Facility Name and City:	
When do you want to present your case?	April 12 July 12 October 11 May 10 August 9 Urgent* June 14 September 13

*Urgent cases will receive a response from the Clinic Medical Director as soon as possible to assess the case

Please send to: Endo ECHO Clinic Coordinator — endoecho@npaihb.org
Phone: 503.228.4185 • Fax: 503.228.4801

Endocrinology TeleECHO™ Clinic

— DIABETES (ADULT) CASE PRESENTATION TEMPLATE —

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:**_______________

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

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

Endo (Diabetes – Adult)

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

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

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_____________	

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

Psychiatric History:

Depression: PHQ9 Administered? ☐ No ☐ Yes – Score:_________ Date:__________ *Suicidality*: ☐ Yes ☐ No

Diagnosis & Treatment History:

Vitals:

Date: ________________ Systolic BP: _____________ Diastolic BP: ____________ Pulse: _________________

Height: ________________ Weight: ________________ ☐lbs. ☐ kgs. BMI: __________________

Physical Exam:

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

Pertinent Others: ____

Health Maintenance:

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

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: _____________

Sexual Dysfunction Screening: Date: : ______________ ☐ Normal ☐ Abnormal__________________________

Current Labs:

HbA1C: Current _______, Previous________ ________ Total Chol: ___________ Triglycerides:_______

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

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

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

Other: ____

Other Comments:

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

Describe: ____
Does Patient Use Tobacco Products? ☐ No ☐ Yes – Number per day (1 pack = 20): _______________
Does Patient Drink Alcohol? ☐ No ☐ Yes – Number of drinks per week: ________________________

Medication Allergies: ____

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

Med Name	Dosage & Frequency	Missed Doses
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Insulin Pump: ☐ No ☐ Yes – Type: ______________________ (attach pump settings if available)

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: _______
Self-Reported Data? ☐ Yes ☐ No

CHW to Present

Social History:
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partnership
Literacy level of patient or caregiver: ☐ Limited ☐ Moderate ☐ Adequate

Household Members: ☐ Parents ☐ Grandparents ☐ Spouse/Partner ☐ Children ☐ Grandchildren ☐ Siblings
☐ Other: ____

Primary Source of Income: ☐ Full-time work, ☐ Part-time work, ☐ Pension/Retirement, ☐ SSI, ☐ Social Security ☐ Disability, ☐ SNAP/Food Stamps, ☐ Unemployment, ☐ VA Benefits, ☐ Social Security, ☐ TANF, ☐ WIC, ☐ No Income, ☐ Other:__________________________________

Social Support: ____

Patient Strengths:

Barriers to Treatment: Access to: ☐ Healthcare, ☐ Medication/Supplies, ☐ Transportation, ☐ Food, ☐ Housing, ☐ Social Support, ☐ Other Access Concerns: ___________________________________,
☐ Cultural Factors/Beliefs, ☐ Financial, ☐ Knowledge about Diabetes, ☐ Language,
☐ Other Barriers: ____

Patient Goals: ____

Healthcare Team's Primary Goals for Treatment: ____

CHW to Present

24 Hour Diet Recall:

Meal and Description	Location of Meal	Portions	Snacks/Drinks* b/w Meals
Breakfast:			**B/W Breakfast and Lunch**
Lunch:			**B/W Lunch and Dinner**
Dinner:			**After Dinner**

**Include water intake*

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

Interventions – What have you done so far?

Social Services Pathways: ☐Domestic Violence, ☐ Disability, ☐ Education/GED, ☐Employment, ☐ Food Security, ☐ Healthcare Insurance Access, ☐ Housing, ☐ Literacy Assistance, ☐ Medicine/Pharmacy Access, ☐ Transportation ☐ Other: ____

Medical Pathways: ☐ Alcohol Use, ☐ Blood Pressure, ☐ Blood Glucose Monitoring, ☐ Carbohydrate Counting, ☐ Cholesterol, ☐ Dental, ☐ Depression, ☐ Diet, ☐ Exercise, ☐ Explanation of Diabetes, ☐ Eye Health, ☐ Foot Health, ☐ High Blood Sugar, ☐ Label Reading, ☐ Low Blood Sugar, ☐ Medication Adherence Counseling, ☐ Sick Day Management, ☐ Lab Tests, ☐ Tobacco Use, ☐ Vaccines, ☐ Waist, Weight, BMI, ☐ Other: ____________________

Plan – What's your plan for this patient moving forward?