Oklahoma State University Addiction Medicine TeleECHO™ Clinic

ECHO ID Request Form

Complete ALL ITEMS on this form and email or email to Courtney Busse-Jones bussejo@okstate.edu

***Required items in order to DE-identify your case.** **Patient ID #: AM-2021-**

1. Patient Gender*:	
2. Patient Region:	
3. Provider Phone Number:	
4. Provider Fax Number:	
5. Provider Email:	
6. 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 OSU-CHS 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 Courtney Busse-Jones at 918-592-3246 immediately.

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Case Presentation Template

Date: _____ **Presenter Name**: _____ **Clinic Site:** _____
ECHO ID: AM-2021-___ ☐ **New Presentation** ☐ **Follow Up Presentation** **Gender:** ☐ Male ☐ Female ☐ Other
Pt Age: ____ **Race:** ☐ Black ☐ White ☐ Asian ☐ Native ☐ Mixed-Race ☐Other _____

Current Psychiatric/Substance Use Diagnoses:

☐Alcohol Use Disorder
☐Opioid Use Disorder
☐Anxiolytic Use Disorder
☐Stimulant Use Disorder
☐Depressive Disorder
☐Bipolar Disorder
☐Anxiety Disorder
☐Posttraumatic Stress Disorder
☐ Psychotic Disorder

What is your main question for this presentation?

History of present illness:

Additional relevant information for case:

MENTAL HEALTH AND SUBSTANCE USE DISORDER MEDICATIONS

Name	Strength	Sig	Indication	Start Date

ALL OTHER MEDICATIONS (Rx, PRN, OTC, Herbals, etc)

Name	Strength	Sig	Name	Strength	Sig

PAST MEDICATIONS USED FOR PSYCHIATRIC DIAGNOSES AND SUBSTANCE USE DISORDERS

Names:	

Laboratory Results

☐ **Liver Function**	Date:	ALT_____ AST_____ ALP_____
☐ **Renal Function**	Date:	Creatinine_____ BUN_____
☐ **Drug Screen**	Date:	Positives_____
☐ **Other relevant labs**		

Past Substance Use and Mental Health History

☐Past Psychiatric Hospitalizations	
☐History of Suicide Attempts	
☐Past Substance Use Treatment	

Social History

Relationship:	☐ Married ☐ Single ☐ BF/GF ☐ Widowed ☐ Unknown
Legal Problems:	☐ Pending Drug or Alcohol Charge ☐ Probation ☐ Drug Court Sanction ☐ Other _____
Stable Housing:	☐ Yes ☐ No
Employment:	☐ Unemployed ☐ Employed Full Time ☐ Employed Part Time ☐ Disabled
Insurance/Payer/Self-Pay:	☐ State Ins (Medicare/Medicaid) ☐ Private Ins ☐ Self Pay ☐ Other _____
Counseling Services Utilized:	