Oklahoma State University Infant Mental Health TeleECHO™ Clinic

ECHO ID Request Form

Complete ALL ITEMS on this form and e-mail to Jade Goodson at jade.goodson@okstate.edu

***Required items in order to DE-identify your case.** **Patient ID #: IMH21-**

1. Patient Gender* (if applicable)	
2. Region:	
3. Presenter Phone Number:	
4. Presenter Fax Number:	
5. Presenter 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.

Date: _____ **Presenter Name**: _____ **Site:** _____
ECHO ID: IMH-21-___ ☐ **New Presentation** ☐ **Follow Up Presentation**
☐ **Case Presentation (complete pages 2-3)** ☐ **System/Program Presentation (complete page 4)**
If Case Presentation:
Gender: ☐ Male ☐ Female ☐ Other
Pt Age: ____ **Race:** ☐ Black ☐ White ☐ Asian ☐ Native ☐ Mixed-Race ☐Other _____

If Case Presentation complete pages 2-3. If System/Program Presentation, complete page 4.

Case Presentation:

Current Diagnoses (check all that apply):

- ☐ Relationship Disorder
- ☐ Anxiety Disorder
- ☐ Developmental Delay
- ☐ Mood Disorder
- ☐ Trauma/Stress Disorder
- ☐Attention Deficit Disorder
- ☐Intellectual Disability
- ☐Learning Disorder
- ☐Obsessive Compulsive and Related Disorder
- ☐Oppositional Defiant Disorder
- ☐Autism Spectrum Disorder
- ☐Other

What is your main question for this presentation?

Case History:

Therapeutic Interventions:

Developmental History (Pregnancy, Birth, Milestones, Concerns)

Trauma History

Medical History

Family Psychiatric History

Mother	
Father	
Siblings	
Other	

Social History

Current living situation:	
DHS Involvement:	☐ Yes ☐ No
Insurance/Payer/Self-Pay:	☐ State Ins (Medicare/Medicaid) ☐ Private Ins ☐ Self Pay ☐ Other _____

MEDICATIONS (Rx, PRN, OTC, Herbals, etc.)

Name	Strength	How it is taken	Indication	

System/Program Presentation:

Please identify the primary concern and the goal for this system/program presentation.
What is currently working well with the system/program?
If applicable, describe contributing factors that may have kept the system/program for progressing to the desired level.