Oklahoma State University Pediatric Behavioral and Emotional Health TeleECHO™ Clinic

ECHO ID Request Form

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

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

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Case Presentation Template

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

Current Psychiatric Diagnoses (check all that apply):

☐Major Depressive Disorder
☐Generalized Anxiety Disorder
☐Developmental Delay
☐Autism Spectrum Disorder
☐Posttraumatic Stress Disorder
☐Attention Deficit Disorder
☐Intellectual Disability
☐Learning Disorder
☐Social Anxiety Disorder
☐Oppositional Defiant Disorder
☐Panic Disorder
☐Schizophrenia
☐Bipolar Disorder
☐Other

What is your main question for this presentation?

History of present illness:

Developmental History (Pregnancy, Birth, Milestones, Concerns)

e.g. born at 32 weeks, history of intra-uterine drug exposure, concern for speech delay

Medical History

e.g. history of chronic ear infections

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 _____
Current School Placement:	☐IEP ☐ 504 Plan Current School/District _____
Current Substance Use:	☐ Alcohol (> 3 Drinks/Day) ☐ RX ☐ Methamphetamine ☐ Marijuana ☐ Other _____

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

Name	Dosage	Indication	Start Date
e.g. Sertraline	100mg Daily	Depression	6/20/2018

Current Therapies (Behavioral, Family, Occupational, Speech, etc)

Therapy	Indication/Course/Challenges
e.g. Cognitive Behavioral Therapy	Depression/6 sessions/Limited family engagement

Previous Psychiatry MEDICATION Trials

Name	Dosage	Response/Side effects
e.g. Citalopram	10mg daily	Stomach pain, not effective

Past Therapies (Behavioral, Family, Occupational, Speech, Therapy)

Therapy	Indication/Course/Challenges/Reason for Termination
e.g. Supportive Therapy	Depression/2 years/depression continued no response, d/c March 2018

Additional Past Psychiatric History

☐Past Psychiatric Hospitalizations	e.g. acute inpatient stay 2016, 3 weeks for suicide attempt
☐History of Suicide Attempts	e.g. 3 prior attempts overdose of medications
☐Other Information	e.g. neuropsychological testing done 7/01/2017