Oklahoma State University Psychiatry TeleECHO™ Clinic

ECHO ID Request Form

Complete ALL ITEMS on this form and email to Megan Claybrook:
megan.claybrook@okstate.edu

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

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.

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Case Presentation Template

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

Current Psychiatric Diagnoses:

☐Major Depressive Disorder ☐Schizophrenia ☐Panic Disorder
☐Generalized Anxiety Disorder ☐Schizoaffective Disorder ☐Posttraumatic Stress Disorder
☐Bipolar Disorder ☐Social Anxiety Disorder ☐ Other: ___

What is your main question for this presentation?

History of present illness:

Additional relevant information for case:

MENTAL HEALTH 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

Names:	

Side Effects/Toxicity

☐ **AIMS**	Date:	Score:
☐ **Lipids**	Date:	TC____ LDL ____ HDL ____ TG ____
☐ **Lithium**	Date:	Level:
☐ **Other relevant side effects/toxicities:**		

Past Psychiatric History

☐Past Psychiatric Hospitalizations	
☐History of Suicide Attempts	
☐Other Information	

Social History

Relationship:	☐ Married ☐ Single ☐ BF/GF ☐ Widowed ☐ Unknown
Current Substance Use:	☐ Alcohol (> 3 Drinks/Day) ☐ RX ☐ Methamphetamine ☐ Marijuana ☐ 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:	