ECHO ID #:

Extension for Community Healthcare Outcomes

Rheumatology
teleECHO™ Clinic Case Presentation Form

Complete ALL ITEMS on this form and fax to 505-272-6906.

1. Patient First Name:	
2. Patient Last Name:	
3. Patient Birthday: (month/day/year)	
4. Patient Gender:	
5. Clinician Phone Number:	
6. Clinician Fax Number:	
7. Clinician Email:	
8. Clinic/Facility Name:	
9. Clinic/Facility City:	
When do you want to present your case? Date and approximate time?	

***When we receive your case, we will email or fax you a confidential patient ID number (ECHO ID) that must be utilized when identifying your patient during clinic.**

PLEASE NOTE that Project ECHO® case consultations do not create or otherwise establish a provider-patient relationship between any UNMHSC clinician and any patient whose case is being presented in a Project ECHO® setting

Project ECHO | UNM SCHOOL of MEDICINE | Internal Medicine

ECHO ID #:

Rheumatology TeleECHO Clinic

— Case Presentation Form —

Date: ___ / ____/ _____ **Presenter:** _____/ _____ **Clinical Site:** _____
FIRST LAST

Patient Name: _____/_____
FIRST LAST

Age: _____ **DOB:** ____/____/ ____ **Gender:** ☐ **Male or** ☐ **Female**

Check One: ☐ **New Case or** ☐ **Follow-up** **Molina patient?** ☐ **Yes** ☐ **No**

Occupation: _____ **Educational Level** _____

WHAT IS YOUR MAIN QUESTION ABOUT THIS PATIENT?

_____

Current and past medical history (e.g. CAD/HTN, AODM, OA, RA, etc. ☐ N/A):

_____

Surgical history (☐ N/A)?

_____

_____

Meds List:

_____

_____

_____

_____

Personal/Social history:

Depression/anxiety: ☐ Yes ☐ No **Family HX:** ☐ Non-contributory ☐ Contributory

Fatigue: ☐ Yes ☐ No **Cognitive problems:** ☐ Yes ☐ No **Blood transfusions/IV drug-use:** ☐ Yes ☐ No

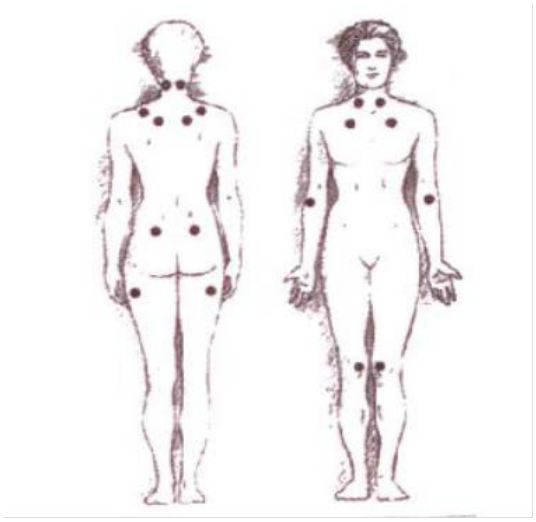
Weight loss: ☐Yes ☐No

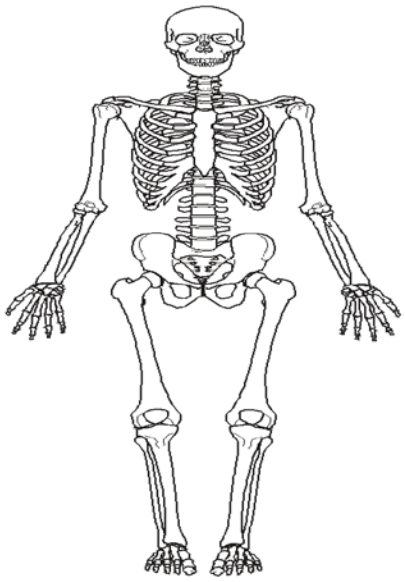
Skin/mucosa: ☐ Yes ☐ No **Thyroid:** ☐ Yes ☐ No **Lymph nodes:** ☐ Yes ☐ No

Lungs: ☐ Yes ☐ No **Heart:** ☐ Yes ☐ No **Abdomen:** ☐ Yes ☐ No

Neurologic: ☐ Yes ☐ No **Pulses:** ☐ Yes ☐ No

Patient Name _____ **ECHO ID #:**





Lab and imaging:	**Date of Draw**		***value, if abnormal**
WBC	☐ nl	☐ abnl	_____
HgB	☐ nl	☐ abnl	_____
Platelets	☐ nl	☐ abnl	_____
AST	☐ nl	☐ abnl	_____
ALT	☐ nl	☐ abnl	_____
Albumin	☐ nl	☐ abnl	_____
INR	☐ nl	☐ abnl	_____
Total Bilirubin	☐ nl	☐ abnl	_____
Creatinine	☐ nl	☐ abnl	_____
CRP	☐ nl	☐ abnl	_____
ESR	☐ nl	☐ abnl	_____
RF	☐ nl	☐ abnl	_____
Anti-CCP	☐ nl	☐ abnl	_____
HLA-B27	☐ nl	☐ abnl	_____
Lupus Anticoagulant	☐ nl	☐ abnl	_____

OTHER

_____

Patient Name _____ **ECHO ID #:**

Joint Fluid Cell Count: _____ ☐ nl ☐ abnl _____

Crystal/Gram Stain: _____ ☐ nl ☐ abnl _____

Fluid Culture: _____ ☐ nl ☐ abnl _____

Imaging: ☐ nl ☐ abnl _____

_____

_____

_____

MY IMPRESSIONS: RA ☐ SLE ☐ OA ☐ FM ☐ AS ☐

Other _____

RHEUMATOLOGIST RECOMMENDATIONS:

IMPRESSION: RA ☐ SLE ☐ OA ☐ FM ☐ AS ☐

Other_____

_____

LABS recommended

_____

_____

IMAGING recommended

_____

_____

Rx / Therapies: _____

_____

_____

Date to Re- Present This Case To Rheumatology TeleECHO Clinic _____

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Rheumatology teleECHO™ Clinic
Phone: 505.750.ECHO (3246) • FAX 505.272.6906