HEALTH SCIENCES

Project ECHO®

Project ECHO® Extension for Community Healthcare Outcomes Miners' Wellness TeleECHO™ Case Presentation Form

Complete ALL ITEMS on this form and email to:
minerswellnessecho@salud.unm.edu (fax not currently accepted)

1. Provider Name:	
2. Provider Phone Number:	
3. Provider Fax Number:	
4. Provider Email:	
5. Provider Clinic/Facility Name, City and State*:	
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 UNMHSC clinician and any patient whose case is being presented in a Project ECHO setting.

***Required items. 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 the teleECHO clinic.**

ECHO ID: ☐ New Case ☐ Follow-up Case

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PLEASE BRIEFLY STATE ONE MAIN QUESTION FOR DISCUSSION: (detailed questions can be provided in the section titled Clinical and non-Clinical Management Questions):

Question:

PLEASE CHECK ALL BOXES RELEVANT TO THE MANAGEMENT QUESTIONS

By presenting this case, I hope to obtain

☐ Help with diagnosis ☐ Help with clinical management ☐ Help with test quality/interpretation
☐ Help with legal/benefits counseling ☐ Other – please state

Patient demographic information

☐ Male ☐ Female
Age (in years)
State of primary current residence
☐ NM ☐ WY ☐ UT ☐ MT ☐ Other

Primary insurance:
Secondary insurance:

Smoking history
☐ Current smoker ☐ Former smoker ☐ Never smoked
If applicable, cumulative pack-years of smoking

Occupational History **Please check details of mining/milling/transportation exposure**

Coal	**Uranium**	**Metal or Non-metal (including sand, gravel, quarry workers, and others)** Type of metal or non-metal exposure:______
Duration of exposure in years: Year of start of exposure: Year of end of exposure:	Duration of exposure in years: Year of start of exposure: Year of end of exposure:	Duration of exposure in years: Year of start of exposure: Year of end of exposure:
Sites: ☐ Underground mine ☐ Above ground mine ☐ Mills ☐ Transportation related to mine/mill ☐ Multiple sites of exposure	Sites: ☐ Underground mine ☐ Above ground mine ☐ Mills ☐ Transportation related to mine/mill ☐ Multiple sites of exposure	Sites: ☐ Underground mine ☐ Above ground mine ☐ Mills ☐ Transportation related to mine/mill ☐ Multiple sites of exposure

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Medical History and Examination Please check symptoms, if applicable

Symptom	Yes (Y) or No	If yes, year of onset (yyyy) or age of onset (in yrs.)	Comment, if applicable
Dyspnea on exertion			
Dyspnea at rest			
Cough			
Phlegm			
Wheeze			
Other			

Please check if the patient has a clinical provider-given diagnosis for the following, if applicable

Symptom	Yes (Y) or No	If yes, year of onset (yyyy) or age of onset (in yrs.)	Comment, if applicable
COPD-emphysema phenotype			
COPD-chronic bronchitis phenotype			
Pulmonary fibrosis			
Pneumoconiosis/Silicosis			
Secondary pulmonary hypertension/cor pulmonale			
Asthma			
Other			

Please describe the following examination findings

Date of examination

Height (inches) Weight(lbs.) BMI (kg/m2) Lung auscultation findings

Pedal edema

Clinical Tests: Please check if the patient has had any of the following tests, if applicable

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*** You may attach test results if you wish, but please black out any personally identifying information.***

Test	Date of test (MM/DD/YYYY)	Absolute value and/or % predicted	Comment on Quality
Prebronchodilator spirometry			
Postbronchodilator spirometry			
Lung volume			
Diffusing capacity			
Arterial blood gas at rest			
Arterial blood gas with activity			
Chest radiograph			
B-read of chest radiograph			
Other			

If serial spirometry tests are available, please summarize the relevant ones below.

Date of test (MM/DD/YYYY)	Weight in pounds	Prebronchodilator FVC (Ls. and % predicted)	Prebronchodilator FEV1(Ls. and % predicted)	FEV1/FVC ratio

*** You may attach test results if you wish, but please black out any personally identifying information.***

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Please check if the patient has applied for any of the following benefits

	Does this patient's history and clinical tests qualify him/her for this benefit? Yes/No	Has patient applied for this benefit? Yes/No	Has patient been approved for this benefit? Yes/No	Comment, if applicable
Uranium workers- Energy Employment Occupational Illness Compensation Program				
Coal workers -Black Lung Benefits Act				
Social Security Disability				
Workers' Compensation/Others				

Clinical and non-Clinical Management Questions

1.
2.
3.

* *You may attach medication lists/chart notes, but please black out any personally identifying information.*
By initialing here ________you have understood 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.

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