CASE PRESENTATION TEMPLATE

Project ECHO: Nursing Home

iECHO Identifier: _____*(Hub Team to Determine)* **Date: _____**

Your Name: _____ **Your Location: _____**

What is the clinical question you hope to be answered during the session? *(for example: how to treat the patient's condition, how to diagnose/evaluate patient's complaints, how to address the patient's functional or cognitive issues, when to provide follow-up care for the patient's condition)*

Patient Information:

◯ **New Project ECHO Patient** ◯ **Follow-up Project ECHO Patient**

Age:_____ **Gender**: ◯ Male ◯ Female ◯ Other: _____

Facility Admit Date: _____

Race/Ethnicity:

◯ American Indian/Alaska Native ◯ Asian ◯ Black or African American ◯ Hispanic or Latino
◯ Native Hawaiian or Other Pacific Islander ◯ White ◯ Other: _____

Changes to Clinical Condition:

☐ ADL Decline

☐ Anxiety/Depression/Behavioral Change

☐ Bowel/Bladder

☐ Chest Pain/Pressure or Palpitations

☐ Fall/Fear of Falling

☐ Gastrointestinal

☐ Neurological Changes/Confusion

☐ Pain

☐ Sensory Changes

☐ Skin Problems

☐ Sleep Disturbance

☐ SOB/Difficulty Breathing

☐ Weight/Appetite

☐ Other _____

Further explanation of changes to clinical condition:

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Significant Past Medical/Surgical History:

Social/Behavioral History (past occupation, hometown, family involvemnet, etc.)

Allergies

Medications

Medication	Dose	Frequency	Medication	Dose	Frequency

Functional Status/ADLs:

Please select Independent, Dependent, or Needs Assistance for each ADL.

Independent	Dependent	Needs Assistance	ADL
○	○	○	Ambulating
○	○	○	Bathing
○	○	○	Bed Mobility
○	○	○	Dressing
○	○	○	Eating
○	○	○	Hygiene/Grooming
○	○	○	Medications
○	○	○	Telephone
○	○	○	Toileting
○	○	○	Transferring

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Pertinent Physical Exam Findings:

Height: _____ **Weight**: _____ **BMI**: _____

Vital Sign Trends:

Date	Temp	Blood Pressure	Heart Rate	Respiratory Rate	O2 Sat

Vital Sign Trend Additional Information:

Pertinent Lab/Imaging *(please include the last creatinine)*

Does this patient have a terminal illness or end-stage disease process?

_____Yes _____No _____Unknown

If yes, please identify:

Would you be surprised if this person passed away in the next 6-12 months?

_____Yes _____No _____Unknown (*if unknown, refer to the prognostic tool on eprognosis.org*)

Have the following been completed/reviewed recently?

- ☐ Advance Care Planning
- ☐ Advance Directive
- ☐ Durable Power of Attorney
- ☐ Goals of Care Conversation
- ☐ Living Will
- ☐ POST/MOST

Additional information:

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What has been your approach/plan of action for addressing/managing this issue?

Describe the patient outcomes related to your approach/plan of care for addressing/managing this issue?

***BEFORE SUBMITTING*, please ensure you are HIPAA compliant by removing all Protect Health Information (PHI) from your form.**
Submit your completed form by clicking the button below.

Submit Form

Contact Person: Kristi Sidel (605)322-2660 or Kristi.Sidel@avera.org