

Email your completed form to projectecho@amerihealthcaritas.com.

As you complete this form, please provide as many details as possible about the case, while excluding PHI and protecting your patient's identity.

Submitted by:	Preferred presentation date:
1. What do you hope to achieve by presenting this case? (e.g., second opinion, referral, treatment ideas):	
2. What matters most to the member or what makes them feel satisfied, content, comforted, fulfilled, and/or happy?	
3. What is important for the member with regard to their treatment (in their own words)?	
4. What, if any, social determinants of health are to be considered as potentially impacting health, wellness, and health behaviors?	

History of present illness/concern

Primary diagnosis/concern:

Onset:

Intensity:

Duration:

Frequency:

Recent treatment interventions:

Specialist care:

Surgeries:

Hospitalizations/outpatient/inpatient:

Emergency room use:

Other diagnoses/concerns:

Behavioral health concerns (trauma and/or substance use):

Relevant social history (home, school, employment, relationships per the member/individual's report):

Past treatment interventions:



History of present illness/concern

Current medications:

Previous relevant medications (please include the member's/individual's report of success/improvement or reasons for discontinuing, as well as your own professional observations):

Family history (please include the member's/individual's report of what is working or not working in their life in terms of family relationships):

Was an assessment, measure, scale, or screening tool used?

Yes (specify which one):

No

If yes, include details below (scores on assessment).

Brief health screen:

Fasting blood glucose:

Patient Health Questionnaire-9:

Cholesterol:

Drug screen:

Thyroid panel:

Blood pressure:

Other:

Who is currently providing treatment services to the patient/family (e.g., M.D./D.O., C.N.P., counselor/social worker, case manager, and/or team)?

Who is supporting the member/individual at home, work, school, or other places?

Is there communication between the patient's PCP and any behavioral health providers involved in the patient's care? Does this need to be established?



Member/individual information			
Race:			
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> White		
<input type="checkbox"/> Asian	<input type="checkbox"/> Multiracial:		
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Other:		
<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Prefer not to say		
Primary/preferred language:			
<input type="checkbox"/> English	<input type="checkbox"/> French	<input type="checkbox"/> Korean	<input type="checkbox"/> Farsi
<input type="checkbox"/> Spanish	<input type="checkbox"/> German	<input type="checkbox"/> Japanese	<input type="checkbox"/> Hindi
<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Chinese	<input type="checkbox"/> Laotian	<input type="checkbox"/> Other (specify):
<input type="checkbox"/> Arabic	<input type="checkbox"/> Italian	<input type="checkbox"/> Armenian	
<input type="checkbox"/> Portuguese	<input type="checkbox"/> Tagalog	<input type="checkbox"/> Russian	
Gender identity:			
<input type="checkbox"/> Male	<input type="checkbox"/> Genderqueer / Gender-nonconforming		
<input type="checkbox"/> Female	<input type="checkbox"/> Other (specify):		
<input type="checkbox"/> Transgender male / Trans man / FTM	<input type="checkbox"/> Prefer not to say		
<input type="checkbox"/> Transgender female / Trans woman / MTF			
What sex was the member/individual assigned at birth?			
<input type="checkbox"/> Male	<input type="checkbox"/> Other (specify):		
<input type="checkbox"/> Female	<input type="checkbox"/> Prefer not to say		
Religious affiliation:			
<input type="checkbox"/> Christianity	<input type="checkbox"/> Buddhism		
<input type="checkbox"/> Islam	<input type="checkbox"/> Other (specify):		
<input type="checkbox"/> Hinduism	<input type="checkbox"/> Prefer not to say		
<input type="checkbox"/> Judaism			
Living situation:			
<input type="checkbox"/> Secure	<input type="checkbox"/> Transient		
<input type="checkbox"/> Insecure	<input type="checkbox"/> Stable		
<input type="checkbox"/> Fragile	<input type="checkbox"/> Needs attention		
If member/individual is a minor, who must legally be involved as part of care?			
ECHO identifier:			
Please leave this field blank at submission; the coordinator will assign an ECHO identifier to your case.			

Reminder: Use of HIPAA-protected health information (PHI) is strictly prohibited, both verbally and in writing during TeleECHO clinics; recording of any kind is also prohibited. Do not include any PHI identifiers on this form. TeleECHO clinics are not intended to replace a practitioner's clinical judgment; the practitioner is responsible for determining applicable treatment for the patients under his or her care.



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Sources: Adapted with permission from Northeast Ohio Medical University, Department of Psychiatry, via the ECHO Project.

"Person Centered Thinking," The Learning Community for Person Centered Practices, <https://tlcpcp.com/work/person-centered-thinking>.



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