

Endocrinology TeleECHO™ Clinic

— ADRENAL CASE PRESENTATION TEMPLATE —

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

Date: _____ **Presenter Name:** _____ **Clinic Site:** _____

ECHO ID: _____ **New** **Follow Up** **Patient Age:** _____ **Biologic Gender:** Male or Female

Insurance: Medicaid Medicare Private None **Insurance Company:** _____

Race: American Indian/Alaskan Native Asian Black/African American Native Hawaiian/Pacific Islander
 White/Caucasian Multi-racial Other Prefer not to say

Ethnicity: Hispanic/Latino Not Hispanic/Latino Prefer not to say

What is your main question about this patient?

Year of Diagnosis: _____ **Previous Treatments:** _____

Symptoms:

- | | | | |
|---|---|---------------------------------------|--|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Abnormal Menses | <input type="checkbox"/> Acne | <input type="checkbox"/> Anorexia |
| <input type="checkbox"/> Diaphoresis | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Hirsutism | <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Vision Change/Loss | <input type="checkbox"/> Weakness | <input type="checkbox"/> Weight Change: |
| <input type="checkbox"/> Flushing | | | <input type="checkbox"/> lbs kgs. |
| <input type="checkbox"/> Other: | | | |

Past Medical History:

- | | | |
|---|---|--|
| <input type="checkbox"/> Cancer – Type: _____ | <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Head/Brain Tumor/Injury |
| <input type="checkbox"/> Fragility Fracture | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Type 1 Diabetes | <input type="checkbox"/> Type 2 Diabetes | <input type="checkbox"/> Vitamin B12 Deficiency |
| <input type="checkbox"/> Other: | | <input type="checkbox"/> Vitiligo |

Psychiatric History

Depression: PHQ9: _____ Date: _____

Medication Allergies: _____

Current Medications/Vitamins/Herbs/Supplements: Please feel free to attach your patient medication list

Med Name	Dosage & Frequency	Med Name	Dosage & Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History:

- Adrenal Disease Hirsutism Thyroid Disease

Smoking History: *Does patient currently smoke?* No Yes – Number of cigarettes per day (1 pack = 20): _____

Alcohol Consumption: *Does patient currently drink?* – No Yes – Number of drinks per week: _____

Vitals:

Date: _____ Systolic BP: _____ Diastolic BP: _____ Pulse: _____
Height: _____ Weight: _____ lbs. kgs. BMI: _____

Physical Exam:

- Abdominal Striae Auricular Cartilage Calcification Bruising Central Obesity
 Cervicodorsal Hump Facial Plethora Moon Facies Orthostatic Hypotension
 Hyperpigmentation: Generalized; Elbows; Knees; Knuckles; Buccal Mucosa; New Scars
 Proximal Muscle Weakness Supraclavicular Fat Pads Other: _____

Current Labs:

White Blood Cell Count: _____ 10³/mcl Hemoglobin: _____ g/dL
Hematocrit: _____ % Platelet Count: _____ 10³/mcl
Serum Sodium: _____ mmol/L Serum Potassium: _____ mmol/L
Serum Chloride: _____ mmol/L Creatinine: _____ mg/dL
BUN: _____ mg/dL Glucose: _____ mg/dL
TSH: _____ uIU/mL Cortisol: _____ mcg/dL
24 hr. Urine Free Cortisol: _____ mcg/24 hrs Late Night Salivary Cortisol: _____ ng/dL
Aldosterone: _____ ng/dL Plasma Renin Activity: _____ ng/mL/hr
Plasma Catecholamines: _____ pg/mL Plasma Metanepherines: _____ mmol/L
24 hr. urine Catecholamines: _____ mcg/24 hrs 24 hr. urine Metanephrines: _____ mcg/24 hrs
Androstenedione: _____ ng/dL DHEA-Sulfate: _____ mcg/dL
Other: _____

Pertinent Imaging Studies:

- MRI (Pituitary/Adrenals): Date: _____ Normal Abnormal: _____
 CT (Adrenals): Date: _____ Normal Abnormal: _____
 Other: _____

Other Comments: