

## Endocrinology TeleECHO™ Clinic

— DIABETES (ADULT) 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?  Behavioral Health,  Adherence,  Diet,  Injection,  Monitoring,  Medications,  Lab Interpretation,  Resources  Lifestyle (Activity),  Other: \_\_\_\_\_

### Endo (Diabetes – Adult)

Type 1 Diabetes,  Type 2 Diabetes Year of Diagnosis: \_\_\_\_\_ Years on Insulin: \_\_\_\_\_

Family History of Diabetes?  No  Yes

Family History of Early CAD?  No  Yes

### Symptoms:

Blurring Vision  Burning/Numbing of Extremities  Depression  Increased Thirst/Urination  
 Fatigue  Weakness  Weight Change Since Last Clinic Visit: \_\_\_\_\_  Other: \_\_\_\_\_

### PMHx:

Diabetic Gastroparesis  Diabetic Nephropathy  Diabetic Neuropathy  Diabetic Retinopathy  
 Anxiety Disorder  Bipolar Disorder  Coronary Artery Disease  Congestive Heart Failure  
 Depression  Eating Disorder  Hyperlipidemia  Hypertension  
 Hypothyroidism  Obesity  Osteoarthritis  Urinary Tract Infection  
 Peripheral Vascular Disease  Other \_\_\_\_\_

Hospitalizations: Dates of ED visits or hospitalizations since last clinic encounter: \_\_\_\_\_, \_\_\_\_\_

### Psychiatric History:

Depression: PHQ9 Administered?  No  Yes – Score: \_\_\_\_\_ Date: \_\_\_\_\_ Suicidality:  Yes  No  
Diagnosis & Treatment History:

**Substance Use History:** *Does the patient have any history of substance use?*  No  Yes

*Describe:* \_\_\_\_\_

**Does Patient Use Tobacco Products?**  No  Yes – Number per day (1 pack = 20): \_\_\_\_\_

**Does Patient Drink Alcohol?**  No  Yes – Number of drinks per week: \_\_\_\_\_

**Medication Allergies:** \_\_\_\_\_

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

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

**Insulin Pump:**  No  Yes – Type: \_\_\_\_\_ (attach pump settings)

**Continuous Glucose Monitor:**  No  Yes – Type:  Dexcom  Medtronic  Freestyle Libre

**Blood Glucose Monitoring:**  No  Yes – Average Blood Glucose: \_\_\_\_\_ Times Checked/Day: \_\_\_\_\_

*Hypoglycemic episodes/week since last encounter:* \_\_\_\_\_

*Self-Reported Data?*  Yes  No

**Social History:**

Single  Married  Separated  Divorced  Widowed  Other: \_\_\_\_\_

*Literacy level of patient or caregiver:*  Limited  Moderate  Adequate

**Household Members:**  Parents  Grandparents  Spouse/Partner  Children  Grandchildren  Siblings

Other: \_\_\_\_\_

**Primary Source of Income:**  Full-time work,  Part-time work,  Pension/Retirement,  SSI,  Social Security

Disability,  Food Stamps,  Unemployment,  VA Benefits,  Social Security,

WIC,  No Income,  Other: \_\_\_\_\_

**Social Support:** \_\_\_\_\_

**Patient Strengths:**

**Barriers to Treatment:** Access to:  Healthcare,  Medication/Supplies,  Transportation,  Food,  Housing,

Social Support,  Other Access Concerns: \_\_\_\_\_,

Cultural Factors/Beliefs,  Financial,  Knowledge about Diabetes,  Language,

Other Barriers: \_\_\_\_\_

**Patient Goals:** \_\_\_\_\_

**Healthcare Team's Primary Goals for Treatment:** \_\_\_\_\_

**24 Hour Diet Recall:**

Meal and Description	Location of Meal	Portions	Snacks/Drinks b/w Meals
<b>Breakfast:</b>			<b>B/W Breakfast and Lunch</b>
<b>Lunch:</b>			<b>B/W Lunch and Dinner</b>
<b>Dinner:</b>			<b>After Dinner</b>

**Exercise Activity:** *Frequency of exercise (# of times/week):* \_\_\_\_\_ *Average duration of exercise (minutes):* \_\_\_\_\_ *Average intensity of exercise:*  Low  Moderate  High

**Interventions – What have you done so far?**

*Social Services Pathways:*  Domestic Violence,  Disability,  Education/GED,  Employment,  Food Security,  Healthcare Insurance Access,  Housing,  Literacy Assistance,  Medicine/Pharmacy Access,  Transportation,  Other: \_\_\_\_\_

*Medical Pathways:*  Alcohol Use,  Blood Pressure,  Blood Glucose Monitoring,  Carbohydrate Counting,  Cholesterol,  Dental,  Depression,  Diet,  Exercise,  Explanation of Diabetes,  Eye Health,  Foot Health,  High Blood Sugar,  Label Reading,  Low Blood Sugar,  Medication Adherence Counseling,  Sick Day Management,  Lab Tests,  Tobacco Use,  Vaccines,  Waist, Weight, BMI,  Other: \_\_\_\_\_

**Plan – What’s your plan for this patient moving forward?**

**Vitals:**

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

**Physical Exam:**

Foot Exam:  Normal  Abnormal Funduscopy Exam:  Normal  Abnormal  
Pertinent Others: \_\_\_\_\_

**Health Maintenance:**

Immunizations:  Influenza  Pneumococcal  Hepatitis B Dental Exam: Date: \_\_\_\_\_

**Microvascular Screening Results**

Dilated Eye Exam/Retinal Scan: Date: \_\_\_\_\_  Normal  Abnormal -  Mild NPDR,  Moderate NPDR,  Severe NPDR,  PDR

Comprehensive Foot Exam: Date: \_\_\_\_\_  Normal  Abnormal -  Diminished Sensation  
 Diminished Pulses  Ulcer  Wound  Other: \_\_\_\_\_

Urine Albumin to Creatinine Ratio: Date: \_\_\_\_\_  Normal  Abnormal – UACR: \_\_\_\_\_

Sexual Dysfunction Screening: Date: : \_\_\_\_\_  Normal  Abnormal \_\_\_\_\_

**Current Labs:**

HbA1C: Current \_\_\_\_\_, Previous \_\_\_\_\_ Total Chol: \_\_\_\_\_ Triglycerides: \_\_\_\_\_  
HDL: \_\_\_\_\_ LDL: \_\_\_\_\_ ALT: \_\_\_\_\_ AST: \_\_\_\_\_  
BUN: \_\_\_\_\_ Creatinine: \_\_\_\_\_ Glucose: \_\_\_\_\_ GFR: \_\_\_\_\_  
TSH: \_\_\_\_\_ Potassium: \_\_\_\_\_ Proteinuria: \_\_\_\_\_ ( Dipstick,  Lab)  
Other: \_\_\_\_\_

**Other Comments:**