

Integrating Pediatric Mental Health Into Primary Care

ECHO Series



CASE PRESENTATION FORM



Please complete case presentation form and send to Kristie Hechtman

E-mail: khechtman@uphcs.org or Fax: (906) 225-8771

Case Presentation for PEDS ECHO Session/Topic Name: _____

Provider Name: _____ Health Clinic Name: _____

Patient Information

Patient ID*: _____ Age: _____ Gender: _____

*Please use initials and month/day of birth

Ex. Janet Doe DOB 5/9/56 is JD0509

Race: _____ Ethnicity: _____

Information collected from:

___ Patient

___ Patient & Parent/Guardian

___ Other, please specify: _____

Current Psychiatric Diagnoses (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Major Depressive Disorder | <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Social Anxiety Disorder | <input type="checkbox"/> Posttraumatic Stress Disorder |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Generalized Anxiety Disorder | <input type="checkbox"/> Schizoaffective Disorder |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Panic Disorder | <input type="checkbox"/> Obsessive Compulsive Disorder |
| <input type="checkbox"/> Learning Disorder | <input type="checkbox"/> Oppositional Defiant Disorder | <input type="checkbox"/> Other: _____ |

What is your main question for this presentation:

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History of present illness:

Additional relevant information for case (current therapy, school support, behavioral interventions):

Developmental History (Pregnancy, birth, milestones, concerns) :

Medical History :

Trauma History (Caregiver separation, relational stressors, abuse, violence):

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Family Psychiatric History

Mother:	
Father:	
Siblings:	
Other:	

Social History

Current living situation:	
DHS Involvement:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Current School Placement:	<input type="checkbox"/> IEP <input type="checkbox"/> 504 Plan Current Grade Level _____
History of School Challenges and/or Current Stressors:	
Current Substance Use:	<input type="checkbox"/> Alcohol (> 3 Drinks/Day) <input type="checkbox"/> RX <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Marijuana <input type="checkbox"/> Other
Mental Health Screen Scores:	

Current Medications (Rx, PRN, OTC, Herbals, etc.)

Name	Strength	Sig	Indication	Start Date

Previous Psychiatric Medication Trials

Name	Strength	Response/Side effects

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Previous Psychiatric History

Psychiatric Hospitalizations:	
Suicide Attempts or Self harm:	
Harm to others:	

Additional gaps or barriers in clinical processes or resources that make it difficult to deliver care for this patient:

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Thank you!