

Case Consultation Request Form



UW Division of
Pain Medicine

Project ECHO
Extension For Community
Health Outcomes

Complete ****ALL ITEMS**** on this form and fax to 206-598-4576

1. Provider First Name:	
2. Provider Last Name:	
3. Provider Phone Number: (for phone follow-up)	
4. Provider Fax Number: (where medical records & follow-up can be sent)	
5. Clinic/Facility Name:	
6. Clinic/Facility Street Address:	
7. Clinic/Facility Zip Code:	
8. Clinic/Facility County:	
9. Clinic/Facility State:	
10. UW ECHO/Chronic Pain Clinic is on Wednesdays 12-1:30pm. On which Wednesdays (1 st & 2 nd choice) would you like to present the case?	

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Project ECHO/CHRONIC PAIN TELEMEDICINE CLINIC – Consultation Request Form

Echo ID # T- _____ Date _____

Year of Birth _____ AGE _____

Gender [] Male [] Female

Medicaid eligible? [] No [] Yes

My clinic is a FQHC [] No [] Yes

Check positive findings

√ Check-Off List
<input type="checkbox"/> Review of available prescription monitoring program info, ED or Pharmacist info
<input type="checkbox"/> Informed consent and <input type="checkbox"/> pain agreement signed
<input type="checkbox"/> Patient signed release for MH and Substance Abuse/ chemical dependency treatment info

Race/s	Marital Status	Education	Current Medications	Dosage	
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> White <hr/> <div style="text-align: center;">Ethnicity</div> <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Not Hispanic/Latino <hr/> Height _____ ft _____ in Wt in lbs _____ BMI _____	<input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> separated <input type="checkbox"/> widowed <input type="checkbox"/> co-habitation <input type="checkbox"/> other	___ # years of school (or) <input type="checkbox"/> high school diploma <input type="checkbox"/> college degree <input type="checkbox"/> graduate degree <hr/> <div style="text-align: center;">Active commitments</div> ___ Work full time ___ Work part time ___ Volunteer ___ Regular exercise ___ Losing weight ___ MH/Psych counselor ___ Parole officer plan ___ CDP TX program ___ AA NA other	Opioids Non-opioid analgesics Other antidepressants Sedatives and sleep aids Other medications		
Living Situation (a)	Tobacco	Side Effects from Pain Meds?			
<input type="checkbox"/> housing unstable <input type="checkbox"/> homeless <input type="checkbox"/> other _____	<input type="checkbox"/> active smoker <input type="checkbox"/> chewer ___ 'packs per day ___ # smoking years		Morphine equivalent dose: _____ (for an online morphine dose equivalent calculator see www.agencymeddirectors.wa.gov/opiod_dosing.asp)		
Current Labs	Date	Current Labs if done	Draw Date	Current Labs if done	Specimen Date
Required Pregnancy test _____ ___/___/___ Urine drug toxicity screen? ___/___/___ Failed Urine tox screen? Yes No If yes list aberrant substances		Creatinine _____ ___/___/___ ALT/AST _____ ___/___/___ T/D Bilirubin _____ ___/___/___ TP/ALB _____ ___/___/___ PPD _____ ___/___/___		HCV Ab _____ ___/___/___ HCV RNA _____ ___/___/___ HIV _____ ___/___/___ TSH _____ ___/___/___	

Medical History and Exam Findings

Co-morbidities including seizure disorder?	Yes	No	Unk
History or risks falls or fractures?	Yes	No	Unk
Sleep apnea or respiratory disease?	Yes	No	Unk
Signs of IV use on exam?	Yes	No	Unk
Cardiovascular disease?	Yes	No	Unk

Pain History, Functional Goals Locations, Severity, Strategies

Activity/ies the patient is monitoring: _____

How much has pain interfered with the patient’s role function? (Circle the number that at corresponds)

Not at all" Extremely
 O 1 2 3 4 5 6 7 8 9 10

Pain Locations: Any pain? Worst Pain?

- Head
- Neck
- Chest
- Stomach
- Back
- Arm
- Hand
- Buttocks
- Genital/Urinary
- Leg
- Knee
- Foot

Overall questions and concerns that you would like to discuss in the Telemedicine conference?

How intense was the recent pain reported at the last visit?

No pain Extreme pain
 O 1 2 3 4 5 6 7 8 9 10

In the past month, how many “bad days” did the patient report where they needed to take more pain medication than had been prescribed?

___None ___1-2 days ___3-5 days ___More than 5

Pain Management Strategies: (past treatment, what works, what doesn’t? Allergies or intolerances? Compliance with TX plan?)

Echo ID # T- _____

Psychiatric History				
History of other abuse, sexual assault, domestic violence, other trauma?				
Psych hospitalizations or suicide attempts?				
In the two weeks prior to the last visit, how often did the patient report that they				
	Not at all	Several days	More than half the days	Nearly every day
A. Had little interest or pleasure in doing things?				
B. Felt down, depressed or hopeless?				
C. Felt nervous, anxious or on edge?				
Substance Abuse and Opioid Risk Screen				
Opioids: (age of onset + tx history, abuse, diversion other aberrant behavior including receipt of opioids from more than one provider?)				
Risk tool date _____		Item score if female (circle)	Item score if male (circle)	
Check if yes				
1. Family history of substance abuse?				
1.a. Alcohol		1	3	
1.b. Illegal drugs		2	3	
1.c. Prescription		4	4	
2. Personal history of substance abuse?				
2.a. Alcohol		3	3	
2.b. Illegal drugs		4	4	
2.c. Prescriptions		5	5	
3. Age: Mark box if 16-45 years		1	1	
4. History of preadolescent sexual abuse?		3	0	
5. Psychological diseases? Attention Deficit Disorder? Obsessive Compulsive Disorder Bipolar Schizophrenia		2	2	
6 Depression		1	1	
Low Risk 0-3 Moderate Risk 4-7 High Risk ≥ 8 Total Opioid Risk Score _____				_____