Project ECHO® (Extension for Community Healthcare Outcomes)

Indian Country ECHO HCV Initial Case Presentation Form

Presentation Date: Site: Clinician:

What is the primary question you have regarding this patient?

General Information/Demographics

Patient ECHO ID:	**Age:**	**Sex at Birth:** ☐ Male ☐ Female	**Gender Identity:**
Insurance: Medicaid Private Insurance		Patient Assistance Program (PAP) Other:	

Liver related history	☐ Cirrhosis	Any evidence of clinical decompensation? ☐ Ascites ☐ Hepatic Encephalopathy ☐ Variceal Bleed
	☐ Previous HCV Treatment	Year: Drug Regimen: Duration of Treatment: SVR 12 Acheived?
	Year of HCV Diagnosis:	☐ Hepatocellular Carcinoma Year of Diagnosis:

Medical Diagnoses	☐ Diabetes Mellitus ☐ Hepatitis B, Chronic ☐ HIV ☐ Other Relevant Diagnoses:	☐ Seizure Disorder ☐ Solid Organ Transplant --- Year: Organ: ☐ Rheumatoid Arthritis

Psychiatric Diagnoses	☐ Depression ☐ Anxiety ☐ Other:
Depression Screening: (If available)	☐ PHQ9: ________________ ☐PHQ2: ____________________ ☐Other: _____________
Substance Use History	Does the person have a substance use disorder? ☐Yes ☐No
	If yes, ☐ Alcohol ☐ Opiates ☐ Stimulants ☐ Benzodiazepines ☐ Marijuana ☐Other: If yes, date of last use (for each):
	History of injecting drugs? ☐Yes ☐No | If yes, date of last injection drug use:

Current Medications:

Medication name:	Dosage:	Frequency	Medication name:	Dosage:	Frequency

Current Method of Birth Control: ________________________________

If oral contraceptive, does it contain ethinyl estradiol? ☐ Yes ☐ No

To submit a case for presentation, please send completed forms to: bhendrix@usetinc.org

Rev.5.20.2021

Body Mass Index	Height:	Weight:	BMI:

Hepatitis Vaccinations and Labs	Hepatitis A total or IgG antibody: ☐ Positive ☐ Negative	If needed has vaccination been started? ☐ Yes ☐ No
	Hepatitis B surface antibody (anti-HBs): ☐ Positive ☐ Negative Hepatitis B core antibody (anti-HBc): ☐ Positive ☐ Negative Hepatitis B surface antigen (HBsAg): ☐ Positive ☐ Negative	If needed has vaccination been started? ☐ Yes ☐ No

Laboratory

Basic Labs	**Date**	**Results**	**Basic Labs**	**Date**	**Results**	**Other Labs**	**Date**	**Results**
WBC			Alk Phos			AFP[3]		
HGB			AST					
HCT			ALT					
Platelets			T. Bili					
Creatinine			Direct Bili[1]					
Protime/INR			HIV Ab					
Total Prot			HCV RNA					
Albumin			HCV GT[2]					

[1]If available; [2] Genotype; [3] AFP for patients with known or suspected cirrhosis

Fibrosis Score (optional; not required)	**Results**
APRI	
FIB-4	
FIBROTEST	
FIBROSCAN	
For cirrhotic patients only	
MELD	
Child-Pugh	

Please list any imaging or transient elastography results, if applicable (e.g. ultrasound, fibroscan, etc.):

Please list any additional pertinent information about the patient:

PLEASE NOTE that case consultations do not create or otherwise establish a provider-patient relationship between any clinician and any patient whose case is being presented in this clinical setting. Always use Patient ID# when presenting a patient in clinic. Sharing patient name, initials or other identifying information violates HIPAA privacy laws