



Palliative Care Case Presentation Request

Please send requests to:



Hospital/Physician Name: _____

ECHO ID (GDPH Use Only): _____ Date ECHO Presentation: ___/___/___

Patient Age:	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transexual <input type="checkbox"/> M to F <input type="checkbox"/> F to M
Race	<input type="checkbox"/> White <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian/Alaska Native
Hispanic	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Question(s) for ECHO Community:	
Case Scenario	

Treatment Plan aligning with Goals of Care	
Psychosocial input	
Spiritual concerns	



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Please send requests to:

Other/Remarks	
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Medical History (Optional)

<input type="checkbox"/> HTN	<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Tobacco Use
<input type="checkbox"/> Obesity	<input type="checkbox"/> Alcohol Use	<input type="checkbox"/> COVID Positive	<input type="checkbox"/> COVID-Vaccinated	
<input type="checkbox"/> Other: _____				

Current Medication (Optional)

Medication Name/Dose	Medication Name/Dose	Medication Name/Dose