

<p>ECHO Date:</p> <p>Provider Name/Credentials:</p> <p>Location/Facility:</p> <p>Phone:</p> <p>Email:</p> <p>Treatment Team Members:</p>	<p>PLEASE ENTER ONLY DE-IDENTIFIABLE PATIENT INFORMATION</p> <p>Patient Age:</p> <p>Gender:</p> <p>Marital Status:</p> <p>Children in the home:</p> <p>Ages of these children:</p> <p>Primary support system:</p>
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PATIENT DIAGNOSES: Check all that apply, select duration of illness, and list relevant details

- Anorexia Nervosa Details:
- Bulimia Nervosa Details:
- Binge Eating Disorder Details:
- Food Intake Disorder Details:
- Depression Details:
- Bipolar Disorder Details:
- Anxiety Disorder Details:
- Personality Disorder Details:
- Suicidal Ideation Details:
- Insomnia/Sleep Disorder Details:
- Self-harm Behaviors Details:
- Substance Abuse Details:
- Electrolyte Disturbance Details:
- Menstrual Dysfunction Details:
- Low Bone Mineral Density Details:
- Bone Stress Injury Details:
- Pancreatitis Details:
- Celiac Disease Details:
- Food Allergies Details:
- Inflammatory Bowel Details:
- Irritable Bowel Disease Details:
- Other Medical Diagnoses Details:
- Other Psychiatric Diagnoses Details:
- Housing/Finance/Legal issues Details:
- Other Social Issues/problems Details:
- Prior mental health related hospitalization Details:
- Prior eating disorder related hospitalization Details:
- Prior residential treatment for eating disorder Details:

EATING & EXERCISE BEHAVIORS: Check all that apply & list relevant details

Exercise
(check all that apply)

Dietary Restriction
(check all that apply)

Binge Eating
(check all that apply)

Vomiting
(check all that apply)

Substance Use
(check all that apply)

Describe typical food related behaviors in regards to meals, snacks, rules, fears, social dynamics, social media, etc...

VITAL SIGNS:	MEDICATIONS / SUPPLEMENTS:	LAB DATA (with High/Low rating):	
Temperature:		Na:	Plt:
Blood Pressure: /		Cl:	AST:
Pulse Rate:		K:	ALT:
Respirations:		CO2:	Alb:
Height (in):		BUN:	FSH:
Weight (lbs):		Cr:	LH:
BMI Percentile:		WBC:	TSH:
Hx normal BMI:		Hgb:	E2:
Recent wt. change:		Hct:	PRL:
PHQ 9:		DXA: Femoral Neck	Lumbar Spine
GAD 7:		T: Z:	T: Z:

WHAT ARE YOUR MAIN QUESTIONS IN PRESENTING THIS CASE?