

CASE PRESENTATION TEMPLATE
Sports Medicine Clinic
Carol Scott, MD



University of Nevada, Reno School of Medicine
PROJECTECHO
CONNECTING NEVADA'S COMMUNITIES TO SPECIALTY CARE

Date: _____ Your Name: _____ Cell Phone: _____

Patient Name: _____ Check One: New Patient Follow-up

Date of Injury: _____ Hospital or Clinic: _____

Gender: _____ Age: _____ Weight: _____ Height: _____

CHIEF COMPLAINT AND MECHANISM OF INJURY:

PERTINENT MEDICAL/SURGICAL HISTORY:

DIAGNOSTICS:

TREATMENT/THERAPY TO DATE:

WHAT IS YOUR CLINICAL IMPRESSION AND CONCERN ABOUT THIS CASE?

Insurance Information (for tracking purposes only):

Medicare Medicaid Commercial Self-pay Other: _____

FAX COMPLETED FORM TO (775) 327-5112

Contact Person: Chris Marchand, Program Coordinator, (775) 682-8476 or cmarchand@med.unr.edu
Project ECHO Main Office: (775) 682-7740 | <http://med.unr.edu/echo>