

ECHO Occupational & Environmental Medicine

Patient Case Presentation Form



PLEASE FILL OUT THIS FORM ON YOUR COMPUTER

Please do not include any patient identifying information.

This case form is the only document used for your ECHO case. Do not send any supplementary materials or share documents from your screen during the case presentation.

Physicians presenting a case may bill OHIP for case conferences (billing codes K707 or K701).

Date: YYYY/MM/DD	_____	Case ID	_____
Presenter	_____	Profession	_____
Practice location (municipality)	_____	New case or follow up?	_____

REASONS FOR PRESENTING THIS CASE

What are your top 3 goals for this patient or questions for our Expert Hub?

Indicate your patient's goals related to work (in their own words):

PATIENT DEMOGRAPHICS & SOCIAL HISTORY

Age:	_____	Sex:	_____	BMI	_____
Occupation:	_____	Urban/rural:	_____		

Please provide any demographic or social considerations that you think may be relevant to the case

- e.g. race, gender identity, marital status, education, immigration or housing status
- English as a Second Language, social support, veteran status, etc

MEDICAL HISTORY

Summarize the patient case history, including:

- main diagnosis, comorbidities
- relevant physical exam, pain assessment, imaging or lab studies
- barriers to treatment (e.g. substance abuse, psychological barriers to recovery, etc)

Submit completed form to Shireen Harbin at echoem@iwh.on.ca

CURRENT MEDICATIONS

Prescribed, over the counter, supplements/herbal medicine

OTHER THERAPIES OR TREATMENTS

WORK CONTEXT

Indicate if, in your opinion, the patient’s condition may have been caused or exacerbated by work. Include, if known, any information about work restrictions/ limitations or accommodations, or if the patient is off work.

Include, if known, any information relevant to the case, including:

- workplace size, job duties, job tenure, whether the position is unionized
- job hazards (biological, chemical, ergonomic, physical, psychosocial)
- challenges with supervisors or co-workers, job satisfaction, or other barriers to return to work/staying at work (e.g. patient fears about being reinjured, etc).

Indicate if you are in contact with anyone at the workplace (e.g. occupational physician, occupational health nurse, supervisor, human resources, etc).

If this is a WSIB case or a 3rd party insurer is involved, indicate if you are in contact with the case manager.

IMPORTANT: Please save this document as a PDF to avoid losing information

ECHO Staff Use:

ECHO staff have reviewed this form and have ensured that no patient identifying information is present.

Initials: _____

Date:
YYYY/MM/DD

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