

Violence Prevention and ACEs Community Member Case Presentation Form

ECHO ID:

**Basic Information:**

Provider Name:	Presentation Date:
Agency Name:	City/State:
Community Member Gender:	Community Member age:
Tribal Region:	

**Case Summary (3-4 sentences):**

**Pertinent Past Medical/Developmental History:**

**Social History (including family and cultural background):**

**Community Member-identified Issues:**

**Information on perpetrator(s), including perpetrator-victim relationship (e.g., intimate partner, parent, child, “family-like”, kinship, family connections within Indigenous Community):**

**Behavioral Health History:**

Diagnosed or Symptomatic:	Yes	Description
Depression	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>	
Mania/Hypomania	<input type="checkbox"/>	
PTSD	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	

PHQ-2:	PHQ-9:
GAD-7:	ACEs/ <a href="#">PEARLS</a> score:

**Substance Use History:**

Currently Using / Misusing:	Yes	Description
Illicit opioid drugs?	<input type="checkbox"/>	
Prescription opioid drugs?	<input type="checkbox"/>	
Other substances, incl. alcohol?	<input type="checkbox"/>	

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**Substance Use Disorder Treatment History:**

Currently:	Yes	Description
Receiving Medications for Addiction Treatment (MAT)?	<input type="checkbox"/>	
Enrolled in treatment program or other recovery services?	<input type="checkbox"/>	

**Family and Tribal strength and protective factors (e.g., self, peer, family, community, spiritual, or cultural supports, etc.):**

**Cultural and Spiritual Connectivity:**

**Tribal historical and contemporary adversity and inequity:**

**Domestic/Family violence risk factors present in family of origin and extended family (e.g., risk indicators, exposure to DFV, recent separation, physical harm, access to weapons, etc.):**

**Immediate support needs that must be addressed (e.g., risk to children, risk of becoming unhoused, etc.):**

**Has a family violence risk assessment been undertaken?**

<input type="checkbox"/> Brief	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Detailed	<input type="checkbox"/> Unsure
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**Has a safety plan been developed with the community member?**

<input type="checkbox"/> Brief	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Detailed	<input type="checkbox"/> Unsure
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**Detail current service/support involvement and safety measures:**

**DESCRIBE YOUR MAIN QUESTION(S) ABOUT THIS COMMUNITY MEMBER?**

*PLEASE NOTE: By submitting this form, you have acknowledged that Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between an ECHO clinician and any patient whose case is being presented in a teleECHO session. Always use Patient ID# when presenting a patient in clinic. Sharing patient name, initials or other identifying information violates HIPAA privacy laws.*