ConferMED™
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IN COLLABORATION WITH

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

eConsult Examples

TABLE OF CONTENTS

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eConsult Example Cardiology Specialist

CARDIOLOGY eConsult Request

Current Status: Submitted

Referral Information		
eConsult ID: **Status:** Submitted **Dialog Status:** Initial Dialog **Auth Number:** **Decision Date:** **Appointment:**	**Diagnosis:** **Procedure(s):** **Additional Notes:** **Message to Referrer:** If you have any questions or feedback on this consult, please email support@confermed.com	**ICD Code:** **Qty:**

eConsult Dialog	If you would like to rate this consult please click here	
Date/Time:	**From: PCP Name**	**To: CARDIOLOGIST**

eConsult:

57 yo M with a complicated medical history. Pt has a known CAD s/p 7 stents for multivessel disease. PTA took place15 years ago. Pt has been on dual antiplatelet therapy (aspirin 325 +plavix 75) since then. He had not any significant cardiac events until about 1 year ago when pt fell from scaffolding, and had acute traumatic hemorrhagic shock. He was in the ICU. Had elevated troponin which was 2/2 due to acute blood loss and ischemic demand. My concerns are multi-fold. This pt will have future anticipated pelvic surgery. He was also started on forteo by Ortho, which may increased PUD/upper GI bleed.

Please make recommendations on whether he would benefit from DAPT lifelong. I believe his risk for bleeding is increased, especially with his surgeries.

Does the patient need to continue DAPT lifelong?

Date/Time:	From: CARDIOLOGIST	To: PCP Name

Diagnosis:

This patient has multiple risk factors, making the decision to discontinue versus continue lifelong DAPT a complex one. The patient has been treated with ASA and plavix long term secondary to his receiving 1st generation paclitaxil DES (I am assuming), his extensive stenting (7), and possibly complex lesions, such as kissing stents, overlapping stents, bifurcation lesions, or small vessel diameter. There is also the issue of secondary prevention, as the patient is a current smoker and has extensive CAD with newly diagnosed “pre-diabetes.”

The ACC/AHA 2016 guidelines on DAPT duration do not extend beyond a year. If you were going strictly by the guidelines, it is recommended that his plavix be discontinued one year after ACS and placement of DES. However, this patient has been treated for secondary prevention.

Currently, there is consideration for lifelong treatment if he has a 1st generation paclitaxil stent. It is true that his bleeding risk is increased with the addition of plavix to his ASA regimen. He has tolerated DAPT for 15 years and most significant bleeding occurs within the 1st year.

For your patient, I would recommend continuation of DAPT with close surveillance and follow up. I would recommend that his ASA dose be decreased to 81mg daily. I would also counsel him as to the effects of smoking on the vessels. Smoking is highly inflammatory to the vessels and promotes plaque formation. Patients all know their risk of developing COPD and lung CA. However, a good portion of my patients are surprised about the inflammatory response seen in the vessels. This patient needs to stop smoking. I would not consider discontinuation of DAPT at this time due to his smoking, his complex CAD and the fact that he has 1st generation paclitaxil stents (you will need to confirm this).

Go Back to Table of Contents | 1

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eConsult Example Dermatology Specialist

DERMATOLOGY eConsult Request

Current Status: Submitted

Referral Information		
eConsult ID: **Status:** Submitted **Dialog Status:** Initial Dialog **Auth Number:** **Decision Date:** **Appointment:**	**Diagnosis:** **Procedure(s):** **Additional Notes:** **Message to Referrer:** If you have any questions or feedback on this consult, please email support@confermed.com	**ICD Code:** **Qty:**
eConsult Dialog	If you would like to rate this consult please click here	
Date/Time:	**From: PCP Name**	**To: DERMATOLOGIST**

eConsult:

1 week with pustules on face, hysterectomy/ovaries removed 4 mos ago for fibroids.

Date/Time:	**From: DERMATOLOGIST**	**To: PCP Name**

Diagnosis:

It is not uncommon for patients to get some hormonally influenced acne or rosacea after removal of the ovaries as the hormones shift. This appears to be new onset acne rosacea. I would recommend a short course of doxycycline to get this under control while simultaneously starting a topical therapy. Interestingly, this patient also has significant melasma, as shown by the extensive hyperpigmentation of the cheeks. To potentially address both problems, I would advise trying azelaic acid cream. The prescriptions are finacea, azelaic acid 20% cream but sometimes are not covered. Fortunately, there is an affordable over-the-counter option called The Ordinary azelaic acid. It is available online at retailers like amazon for around $10. This helps both rosacea and hyperpigmentation. If the patient would like more extensive treatment for melasma, please send another consult, since there is a specific treatment program for this (but since this isn't the primary complaint, I won't go into details unless desired).

Treatment:

Doxycycline: Doxycycline 100mg twice daily until skin is healed. Some patients may need this in the future for flares and still others use a low dose like 50mg daily for maintenance. Since this is a new problem, it is best to treat the current flare then manage from there.

Azelaic acid: Finacea, Azelaic acid 20% cream, or over-the-counter The Ordinary Azelaic acid serum.

Thank you very much for your consultation. Please do not hesitate to contact me with further questions.

Go Back to Table of Contents | 2

eConsult Example Endocrinology Specialist

ENDOCRINOLOGY eConsult Request

Current Status: Submitted

Referral Information		
eConsult ID: **Status:** Submitted **Dialog Status:** Initial Dialog **Auth Number:** **Decision Date:** **Appointment:**	**Diagnosis:** **Procedure(s):** **Additional Notes:** **Message to Referrer:** If you have any questions or feedback on this consult, please email support@confermed.com	**ICD Code:** **Qty:**
eConsult Dialog	If you would like to rate this consult please click here	
Date/Time:	**From: PCP Name**	**To: ENDOCRINOLOGIST**

eConsult:

Low TSH, elev free T4 and neg Trab, new clinic data pt c/o severe pain off/on anterior neck and some feeling of swelling. Need to know next steps for eval and treatment.

Date/Time:	**From: ENDOCRINOLOGIST**	**To: PCP Name**

Diagnosis:

I have reviewed the attached clinical information for your patient. Please see below for my recommendations.

Diagnosis:

This young woman has mild hyperthyroidism 4 months postpartum with second child. No contributing PMH. She also reports some anterior neck pain (lasting an hour at a time?) and subjective sensation of neck swelling on/off (duration?). TFTs c/w mild hyperthyroidism, TRabs negative. No family hx of thyroid or autoimmune disease listed.

Problem Discussion:

The most likely Dx in this setting is postpartum thyroiditis, which is typically painless. Painful thyroiditis (postviral) usually presents dramatically with severe pain and some appreciable swelling of the thyroid gland. I doubt she would have forgotten to tell you this at the visit. Graves disease can present postpartum, less likely with negative TRabs (I prefer TSIs for better sensitivity, if available in your lab), but still possible.

Further Testing Recommended:

To best differentiate between these possibilities, she should have an I123 thyroid uptake and scan. Since she is not breastfeeding, it should not be an issue, but please follow your local radiology instructions for safety around infants. If not possible to have the nuclear scan done, follow-up closely with TFTs (TSH, FT4, TT3) plus TPO antibodies (she might have Hashimoto's presenting with Hashitoxicosis) in 1-2 weeks, since thyroiditis patients can turn hypothyroid relatively fast and she will probably require thyroid hormone supplementation for at least few months until her thyroid function returns to normal.

Treatment Plan:

Can use a beta blocker for symptoms relief. Would avoid use of stimulant while hyperthyroid. In case her neck pain is significant, NSAIDs can be useful. I reserve steroids for patients with severe, acute pain.

Referral to Specialist?

If we cannot make a clear Dx and she does not progress toward hypothyroidism in the next few weeks, then referral to endocrine in person might be useful.

Please feel free to update me of her progression, so I can make additional management recommendations.

Go Back to Table of Contents | 3

eConsult Example Gastroenterology Specialist

GASTROENTEROLOGY eConsult Request

Current Status: Submitted

Referral Information		
eConsult ID: **Status:** Submitted **Dialog Status:** Initial Dialog **Auth Number:** **Decision Date:** **Appointment:**	**Diagnosis:** **Procedure(s):** **Additional Notes:** **Message to Referrer:** If you have any questions or feedback on this consult, please email support@confermed.com	**ICD Code:** **Qty:**

eConsult Dialog	If you would like to rate this consult please click here	
Date/Time:	**From: PCP Name**	**To: GASTROENTEROLOGIST**

eConsult:

eclinical consult to GI regarding 34 yr old patient with loose stools. Patient reports cramping and chronic loose stools described as diarrhea. Patient has changed diet and now following vegan diet. Clinical history suspect for IBS with diarrhea.

Would like guidance from GI in evaluation and treatment of IBS with diarrhea. What treatment options are for patient with IBS w/diarrhea? Stool studies negative, no wbc in stool, TSH normal, gluten sensitivity assay neg. Are there additional labs that I should order?

Date/Time:	From: GASTROENTEROLOGIST	To: PCP Name

Diagnosis:

34 year old with abdominal pain and diarrhea.

First: Will assume no family history of colon cancer, and that patient is average risk.

Second: Alarm signs will need to be ruled out such as rectal bleeding, occult blood in stools and weight loss.

Third: Need to r/o anemia, and would check sed rate to r/o possible inflammation and Crohn's Disease. Stool for fecal fat if stools are oily or clay colored.

Next step is to rule out intolerance to short chain carbohydrates. A 2-week trial of FODMAP diet attached (FODMAP). FODMAP diet also rules out lactose intolerance as a cause. If all of above negative then can assume IBS with diarrhea.

One option is to either treat patient or test patient for SIBO (small intestinal bacterial overgrowth). The test is a Lactulose Breath test. The treatment is 14 days of Rifaxamin 550mg TID. Must use IBS with diarrhea as diagnosis to get Rifaxamin covered by insurance.

Other option is to just treat IBS with diarrhea with one of following regimens:

1. Viberzi 100mg or 75 mg bid depending on severity. Cannot use if patient has gallstones, Cholecystectomy or pancreatitis history.
2. Probiotics.
3. Imodium AD one tablet a day and titrate to relief. If everything above is unsuccessful then need colonoscopy to r/o occult Crohn's disease, Lymphocytic or Collagenous colitis.

Go Back to Table of Contents | 4

eConsult Example Neurology Specialist

NEUROLOGY eConsult Request

Current Status: Submitted

Referral Information		
eConsult ID: **Status:** Submitted **Dialog Status:** Initial Dialog **Auth Number:** **Decision Date:** **Appointment:**	**Diagnosis:** **Procedure(s):** **Additional Notes:** **Message to Referrer:** If you have any questions or feedback on this consult, please email support@confermed.com	**ICD Code:** **Qty:**

eConsult Dialog	If you would like to rate this consult please click here	
Date/Time:	**From: PCP Name**	**To: NEUROLOGIST**

eConsult:

Patient is requesting an MRI because she is concerned she has MS. She does report having seizures associated with her menstrual cycle. Records available for review are a normal EEG and CT. Patient reports migraine headaches, these also appear to be cyclical. Patient reports she has tried many medications for migraines and has taken antidepressants and hormonal birth control but she states she is "sensitive" and responds differently than others. I don't believe an MRI is warranted for this patient. I believe she has migraines but am unsure how to treat them if she is not willing to take medications. I have encouraged her to see a GYN to discuss non hormonal methods to reduce her menstrual cycles.

My question is: given patient's complaints, is an MRI reasonable to rule out MS, and are there any recommendations for control of migraines outside of the triptans and antihypertensives that may be effective? I recommended amitriptyline, patient did not want to start anything without knowing if she has MS.

Date/Time:	From: NEUROLOGIST	To: PCP Name

Diagnosis:

Age: 41 years

Reason for Consultation: Uncontrolled migraine headache. Head MRI medical necessity.

Clinical Summary: 41-year-old woman who developed menstrual migraine and a report of seizure associated with her migraine. Normal EEG. She tried several medications including antidepressant without clear documentation of the effect of these medications.

Diagnosis: Menstrual Migraine headache.

Recommendation: Head MRI with and without contrast could be helpful to manage this patient. I agree with the provider that MRI is not indicated to rule out MS in this case. The patient has no neurological evidence suggestive for this diagnosis. However, she has intractable headache associated to possible seizure (Normal EEG cannot exclude seizure) not controlled by migraine/pain medication. An organic brain lesion should be excluded. In addition, performing MRI may increase the patient willingness to follow the provider recommendation and use headache medications.

Menstrual migraine. Initial treatment of menstrual migraine should be the same as for migraine occurring at other times: a rapid-onset triptan administered early in the mild pain. An alternative to triptans is NSAIDs. One randomized trial found that mefenamic acid (500 mg every eight hours as needed) was superior to placebo in treatment of acute menstrual migraine (.Al-Waili NS. Treatment of menstrual migraine with prostaglandin synthesis inhibitor mefenamic acid: double-blind study with placebo. Eur J Med Res 2000; 5:176) Initial: 500 mg beginning at the onset of bleeding and associated symptoms, followed by 500 mg every 8 hours; continue for 2 to 3 days.

Reference: Al-Waili NS. Treatment of menstrual migraine with prostaglandin synthesis inhibitor mefenamic acid: double-blind study with placebo. *Eur J Med Res* 2000; 5:176

Go Back to Table of Contents | 5

eConsult Example Pediatric Cardiology Specialist

PEDIATRIC CARDIOLOGY eConsult Request

Current Status: Submitted

Referral Information		
eConsult ID: **Status:** Submitted **Dialog Status:** Initial Dialog **Auth Number:** **Decision Date:** **Appointment:**	**Diagnosis:** **Procedure(s):** **Additional Notes:** **Message to Referrer:** If you have any questions or feedback on this consult, please email support@confermed.com	**ICD Code:** **Qty:**
eConsult Dialog	If you would like to rate this consult please click here	
Date/Time:	**From: PCP Name**	**To: PEDIATRIC CARDIOLOGIST**

eConsult:

16 yo female with 3 episodes of syncope within the last 3 weeks with non-focal neuro exam.

Date/Time:	**From: PEDIATRIC CARDIOLOGIST**	**To: PCP Name**

Diagnosis:

Thank you for your eConsult. I have reviewed your clinic note.

With episodes of presyncope and syncope occurring exclusively on moving from lying to sitting or sitting to standing, chances are good that these are vasodepressor symptoms secondary to mild, common autonomic dysfunction, but there are some additional elements of the history and workup that would be helpful in reducing the risk of missing something more dangerous.

1. **HPI:** Further information as to the prodrome prior to syncope would be helpful. In particular, you'll want to know whether there are palpitations prior to lightheadedness. Many patients feel strong mildly accelerated HR after onset of lightheadedness, which is due to reflex tachycardia after hypotension, but you'll want to know whether there could have been any rapid tachycardia (SVT, VT, etc.) to explain the syncope.

   Were any of the events witnessed? If so, was there pallor?

   Were there any other factors in context? (E.g., during menses, concomitant with any viral illness, with less than normal sleep, etc.)

2. **Family History:** You'll need a careful family history of sudden death, including SIDS, sudden death during exercise or sleep or otherwise. Family history in young people of cardiomyopathy (hypertrophic or dilated), arrhythmia, and congenital heart disease is an important part of the evaluation of syncope.

3. **Electrocardiogram:** An ECG should be performed and interpreted by a cardiologist as surveillance for cardiomyopathy, arrhythmia, QTc prolongation and other pathology that can contribute to or cause syncope.

Below is a link to our Referral Guideline for syncope in case it is helpful to you.

https://www.connecticutchildrens.org/wp-content/uploads/2017/06/RG_Syncope.pdf?pdf=Syncope

If you are unable to acquire the above additional information or if you would prefer a face-to-face visit, we would be happy to assist with that.

Go Back to Table of Contents | 6

eConsult Example Pediatric Dermatology Specialist

PEDIATRIC DERMATOLOGY eConsult Request

Current Status: Submitted

Referral Information		
eConsult ID: **Status:** Submitted **Dialog Status:** Initial Dialog **Auth Number:** **Decision Date:** **Appointment:**	**Diagnosis:** **Procedure(s):** **Additional Notes:** **Message to Referrer:** If you have any questions or feedback on this consult, please email support@confermed.com	**ICD Code:** **Qty:**
eConsult Dialog	If you would like to rate this consult please click here	
Date/Time:	**From: PCP Name**	**To: PEDIATRIC DERMATOLOGIST**

eConsult:

4 year old prev. healthy female presents with one week of worsening erythematous papules on right forearm. Linear arrangement, consistent with scabies, however, not pruritic. TX with permethrin x 1 and had re-occurrence. Did not do scraping for microscope prior to treatment. Dermatoscope pictures did not come out clearly.

Continue to observe or recommend additional treatment?

Date/Time:	From: PEDIATRIC DERMATOLOGIST	To: PCP Name

Diagnosis:

I have reviewed your patient's medical history and photographs.

Diagnosis: Cutaneous lymphangioma circumscriptum. The photographs and clinical history of asymptomatic grouped clear vesicles isolated to one location and unresponsive to treatment is most consistent with lymphangioma circumscriptum. These benign vascular growths comprise about 25% of all benign vascular growths in children. They vary in clinical appearance from clear to pink, or purple. Most other causes of skin lesions, including scabies, allergic contact dermatitis, and zoster with erythema and vesicles are symptomatic, making these diagnoses less likely.

Further testing and evaluation: No further testing is needed unless the lesion changes or becomes symptomatic. However, these lesions can develop a pink or purple color and sometimes become more prominent in puberty. The diagnosis can be confirmed with a 3mm punch biopsy, though children often have trouble tolerating this procedure.

Treatment: Removal of a lymphangioma can be done if desired by the patient for cosmetic reasons. There are a variety of options including electrodessication, cryosurgery, or excision.

Clinical Course: These growths do not resolve but are usually clinically stable with minimal symptoms. They can increase in size or change color as noted above, but significant changes in any lesion warrant further evaluation as an unrelated skin cancer can grow incidentally under or adjacent to a benign lesion.

For additional information, I found the following resource helpful.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4371681/

Thank you for your consultation. Please do not hesitate to contact me with further questions.

Go Back to Table of Contents | 7

eConsult Example Pediatric Endocrinology Specialist

PEDIATRIC ENDOCRINOLOGY eConsult Request

Current Status: Submitted

Referral Information		
eConsult ID: **Status:** Submitted **Dialog Status:** Initial Dialog **Auth Number:** **Decision Date:** **Appointment:**	**Diagnosis:** **Procedure(s):** **Additional Notes:** **Message to Referrer:** If you have any questions or feedback on this consult, please email support@confermed.com	**ICD Code:** **Qty:**

eConsult Dialog	If you would like to rate this consult please click here	
Date/Time:	**From: PCP Name**	**To: PEDIATRIC ENDOCRINOLOGIST**

eConsult:

11 yr old male with 9 months of left gynecomastia associated with clear left nipple discharge 2x/month. Labs normal. Breast US shows gynecomastia w/ left dilated duct/cyst formation.

Does any further work up need to be done?

Date/Time:	From: PEDIATRIC ENDOCRINOLOGIST	To: PCP Name

Diagnosis:

Thank you for your eConsult.

To summarize, this is an 11-year-old boy with obesity and Tanner 3 pubertal exam (last examined 08/2021) presenting with gynecomastia and galactorrhea of < 1-year duration. Pubertal gynecomastia is most common in Tanner stage 3 and 4, is usually self-limited, and typically regresses over 1 to 3 years. In this patient's case, this likely is a combination of pubertal gynecomastia and gynecomastia seen in obesity due to excess aromatization of androgens to estrogens. In general, gynecomastia results from an imbalance in the androgen/estrogen ratio in men (the normal circulating ratio of testosterone to estrogen in adult men in ~300:1), favoring estrogen, or from an excessive breast tissue sensitivity to estradiol.

This patient has a normal male phenotype and testicular exam done 08/2021, which is reassuring. Interval growth velocity and labs done thus far have also been normal. I agree with your opinion that the galactorrhea present in this case is unusual but may be due to neurogenic stimulation. I would however recommend obtaining a detailed history from the patient for symptoms including early morning headaches, visual disturbances, polyuria or polydipsia. In addition, I would also inquire about the use of dietary supplements, herbal products, and medications. Careful attention should be paid to both the breast (skin dimpling and regional lymphadenopathy) and testicular examination (testicular mass or change in testicular consistency) at his follow-up visits. If galactorrhea persists or there are any new symptoms (headaches, visual deficits, polys), I would recommend repeat labs including serum total and free testosterone, Prolactin (with serial dilution to rule out hook effect causing a falsely low level), human chorionic gonadotropin (hCG), TSH, Free T4, LH, and estradiol and a referral to a pediatric endocrinologist.

Otherwise, sympathetic reassurance remains the standard of care for physiologic gynecomastia.

Go Back to Table of Contents | 8

eConsult Example Pediatric Gastroenterology Specialist

PEDIATRIC GASTROENTEROLOGY eConsult Request

Current Status: Submitted

Referral Information		
eConsult ID: **Status:** Submitted **Dialog Status:** Initial Dialog **Auth Number:** **Decision Date:** **Appointment:**	**Diagnosis:** **Procedure(s):** **Additional Notes:** **Message to Referrer:** If you have any questions or feedback on this consult, please email support@confermed.com	**ICD Code:** **Qty:**
eConsult Dialog	If you would like to rate this consult please click here	
Date/Time:	**From: PCP Name**	**TO: PEDIATRIC GASTROENTEROLOGIST**

eConsult:

13 month old F with chronic constipation since starting solids, now with continued constipation despite Miralax clean out and dietary changes to increase more fruits and vegetables. Referred to Peds GI for further recommendations given age.

Date/Time:	From: PEDIATRIC GASTROENTEROLOGIST	To: PCP Name

Diagnosis:

Findings most consistent with functional constipation which appears to be managed with Miralax. If the constipation is well controlled, I would continue Miralax. If not, can consider further workup to look for endocrinopathies, Celiac disease or Hirshsprungs which can be associated with refractory abdominal pain or constipation.

Further testing and evaluation options for the constipation include:

1. Inquire about passage of meconium. Most children pass meconium within the first 24-48 hours. May consider obtaining a barium enema if there is a history of delayed passage of meconium more than 48 hours after birth.
2. Could consider checking for Celiac disease (TTG IgA, IgA level) and thyroid dx (TSH).

Treatment options:

1. Continue Miralax daily to keep stools soft and regular. May adjust dose as needed to achieve soft, effortless stools daily. By keeping the stools soft and painless, this will discourage possible stool withholding behavior which can compound the cycle of constipation and stool withholding. Frequently parents think their children are “straining” when actually the child is trying to avoid defecation as they are actually trying to “hold it in.” Often times families say that medications don’t work and stop giving it prematurely or only give it a sporadic fashion which is less effective. Unfortunately, children quickly associate pain with defecation and the cycle of constipation and stool withholding start all over again. It is better to give it consistently until the problem completely resolves rather than wean off too fast and reinforce in children’s minds that stooling hurts which makes the problem much harder (and longer) to resolve in the long run. If it is working, Miralax is the most recommended laxative as it is the most studied in children compared to it’s alternatives and has been deemed to be safe. In addition, it is also much easier to give as it is tasteless and textureless. If still not effective, however, if families prefer, a different laxative (i.e. lactulose) can be used instead, however, lactulose (and other alternatives) are usually less palatable and can cause cramping. The daily laxative should help keep the stools soft to promote better and more complete bowel evacuation on a regular basis. Miralax is not dosed by age or weight. The appropriate dose for the patient is the dose that effectively achieves your goal stooling pattern. The most important thing is to take the medication REGULARLY, even daily if needed. Typically noncompliance or UNDERdosing is the biggest reason that medications don’t work.
2. Encourage high fiber foods and lots of fluids.
3. If obesity is not a concern, can encourage sorbitol rich fruit juices to help with constipation—prune, pear or apricot nectar. No need to dilute. May be increased if needed. This is in addition to (not substitution for) the laxative.
4. If refractory constipation or other concerns (GI bleeding, weight loss) despite above recommendations (or abnormal testing), may need to refer to GI for further evaluation. This child does not need further testing for colon cancer for history of constipation alone.

Go Back to Table of Contents | 9

eConsult Example Pediatric Neurology Specialist

PEDIATRIC NEUROLOGY eConsult Request

Current Status: Submitted

Referral Information		
eConsult ID: **Status:** Submitted **Dialog Status:** Initial Dialog **Auth Number:** **Decision Date:** **Appointment:**	**Diagnosis:** **Procedure(s):** **Additional Notes:** **Message to Referrer:** If you have any questions or feedback on this consult, please email support@confermed.com	**ICD Code:** **Qty:**

eConsult Dialog	If you would like to rate this consult please click here	
Date/Time:	**From: PCP Name**	**To: PEDIATRIC NEUROLOGIST**

eConsult:

Please refer to progress note for details. Inquiring about prophylactic treatment of migraines and cyclic vomiting syndrome. Previously tried propranolol. Changed to amitriptyline; has taken 20 mg for the past year. Symptoms poorly controlled at this time.

Please provide recommendations for ongoing migraine/abdominal migraine management. Please include GI notes.

Date/Time:	From: PEDIATRIC NEUROLOGIST	To: PCP Name

Diagnosis:

I have reviewed the attached clinical information for your patient. Please see below for my recommendations.

Diagnosis: Migraine headaches without aura, abdominal migraine, and cyclic vomiting syndrome.

Further testing and evaluation: MRI brain without contrast if not done in past 2-3 years.

Treatment plan: Please start Topamax, Cyproheptadine, and Riboflavin as mentioned below.

Topamax:	Week 1: Topamax 25 mg at bedtime Week 2: Topamax 50 mg at bedtime and continue this dose.
Cyproheptadine:	Week 1: 4 mg at bedtime Week 2: 8 mg at bedtime and continue this dose.
Riboflavin:	Week 1: 50 mg at bedtime Week 2: 100 mg at bedtime and continue this dose.

Slow weaning of Topamax and Cyproheptadine after 6 months of headache freedom.

Additional notes:

- Advised to drink 2-3 liters of fluid daily, mainly water
- Avoid excessive caffeine
- Limit screen time
- 8-10 hours of sleep
- Avoid processed food like salami, baloney, and foods containing MSG.

Go Back to Table of Contents | 10