



Case Submission Form

Your name:

Your practice location:

Your role:

Patient Gender:

Patient Age:

Patient location (US City, State or Country):

Please provide a brief clinical summary (5-7 sentences) of the case:

Relevant medical background and history:

Relevant family and social history:

Relevant health behavior history:

Prior treatment, if any:

I am looking for advice on:

- Prevention
- Diagnosis
- Treatment
- Other:

What is your clinical question about this case for the group?

Please submit this form to gvhd@aamds.org