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