WEST PARK HEALTHCARE CENTRE

TRANSITIONAL HOME VENTILATION PROGRAM

PRE-ASSESSMENT REFERRAL

CONTACTS:	Raj Kohli, Coordinator 416-243-3600 ext. 32309; Fax 416-243-3739
	Laura Watling, Manager 416-243-3600 ext. 32350; Fax 416-243-3739

In order to facilitate the assessment, and prompt processing of the application, it is imperative that this pre-assessment form be filled out accurately. In addition a typed clinical/medical summary must be included with this form.

PATIENT NAME: _____ _____

Surname First Name

BIRTH DATE: _____ AGE: _____ SEX: _____ MARITAL STATUS: _____

HEALTH CARD NUMBER: VERSION CODE:

PATIENT'S CURRENT LOCATION: FACILITY: ☐ HOME: ☐

ADDRESS:

PHONE:

REFERRING PHYSICIAN: PHONE:

BILLING #:

FAMILY PHYSICIAN: PHONE:

PRIMARY DIAGNOSIS (please include date of onset):

RELEVANT CO-MORBIDITIES:

MEDICALLY STABLE: YES: ☐ NO: ☐

PROGNOSIS DISCUSSED WITH PATIENT: ☐ FAMILY: ☐

PATIENT CONSENTS TO THIS REFERRAL: YES: ☐ NO: ☐

ADVANCE CARE DIRECTIVES:

CONTACT INFORMATION:

SUBSTITUTE DECISION-MAKER: RELATIONSHIP:

ADDRESS: PHONE NUMBER:

POWER OF ATTORNEY for Healthcare Decisions:

ADDRESS: PHONE NUMBER:

FINANCIAL INFORMATION

PERSON RESPONSIBLE FOR FINANCIAL AFFAIRS: SELF ☐ OTHER ☐ _____

NAME (IF NOT SELF): RELATIONSHIP:

ADDRESS: PHONE NUMBER:

POWER OF ATTORNEY for Financial Decisions:

ADDRESS: PHONE NUMBER:

ACCOMMODATION REQUESTED: STANDARD ☐ SEMI-PRIVATE ☐ PRIVATE ☐

PATIENT GOALS:

What are the patient's short-term goals?

What are the patient's long-term goals?

DISCHARGE PLANS: **Note to referring facility: Any difficulties in completing this section can be discussed with the West Park Healthcare Centre Care Coordinator.**

Does the patient plan to return to the community? Yes ☐ No ☐

If yes: private home? ☐ Attendant facility? ☐ Other? ☐

If other, please state:

Is home accessible? Please describe:

Address:

Phone: Contact Person:

Names of Primary Caregivers★ to be trained, and relationship to patient:

1. Relationship:
2. Relationship:
3. Relationship:
4. Relationship:
5. Relationship:

★ Primary caregivers are those persons who provide all necessary care in the home. Caregivers will always be necessary when the patient is physically unable to care for themselves, i.e. patient is quadriplegic or has severe neuro-muscular deficits rendering him/her unable to care for themselves.

FINANCIAL RESOURCES/COMMUNITY SUPPORTS:

Please list any financial resources available, including the sources & contact information as appropriate (e.g. pensions, private insurance, health and/or disability benefits):

☐ extended health benefits – coverage/limits:

☐ disability benefits (CPP, ODSP)

☐ other:

Please list any additional formal/informal supports/resources accessed in the past:

☐ CCAC

☐ Community Organizations (e.g. ALS Society, MD Association, March of Dimes)

☐ Church Groups

☐ Other:

CURRENT LAB RESULTS:

Hgb _____ K _____ BUN _____ Ca _____

Wbc _____ Na _____ CR _____ Alb _____

HcT _____ Cl _____ Glob _____

MRSA _____ Date _____ PT _____

VRE _____ Date _____ PTT _____

C-Diff _____ Date _____

ABG's: $Fi0_2$ _____ Spontaneous _____ Ventilated: _____

VALUES: PH _____ $P0_2$ _____ PCO_2 _____ $HC0_3$ _____ Date: _____

MEDICATIONS (attach list if more space is needed):

Medication	Dosage	Frequency

VENTILATION NEEDS:

Ventilation Start Date: _____

How many hours/day is the patient using mechanical ventilation? _____

Vent-free time: _____

Is O_2 required while ventilated: _____

Is O_2 required while patient is breathing spontaneously?

VENTILATOR SETTINGS:

Current Ventilator Model: _____

Mode of Ventilation: _____

V_T	_____	c.c.	FiO_2	_____	
Pressure Control	_____	cmH_2O	PEEP	_____	cmH_2O
R.R.	_____	bpm	Pressure Support	_____	cmH_2O

Recent ABG Results on the above settings:

TRACHEOSTOMY:

Trach Tube Type / Size: CUFFED: ☐ UNCUFFED: ☐
FENSTRATED: ☐ UNFENESTRATED: ☐

If cuffed, cuff volume: _____

Date of recent Trach Tube Change: _____

Trach Changes Performed By (i.e. Physician, RRT): _____

Frequency of Trach Changes: _____

Stoma Condition: _____

If patient has vent-free time, is patient able to tolerate cuff deflation or corking?

DIAPHRAGMATIC PACING:

Model: _____

Bilateral Pacing? _____ Unilateral Pacing? _____

Resp. Rate: _____ bpm Right Ampl.: _____ Left Ampl.: _____

How long patient uses pacers?: _____ Hrs/24 hrs.: _____

SUCTIONING:

Frequency: _____

Is the patient able to suction self? _____

Has the patient had a swallowing assessment, including videofluroscopy? _____

Does patient have a problem with aspiration? YES: ☐ NO: ☐

If Yes, please describe:

MANUAL VENITLATION:

How often is patient 'bagged'? _____

When is patient usually 'bagged'? _____

Can patient 'bag' him/herself? _____

Additional COMMENTS: _____

COMMUNICATION:

Is the patient able to speak? YES: ☐ NO: ☐

What it is the language spoken and understood by the patient?

Does the patient require use of a communication device? YES: ☐ NO: ☐

If so, please specify (i.e. communication board, clipboard, mouthing words)

COGNITIVE / EMOTIONAL:

Is the patient alert? Yes ☐ No ☐ Oriented to: Time ☐ Person ☐ Place ☐

	Intact	Impaired
Memory	☐	☐
Judgement	☐	☐
Insight	☐	☐

Does the patient possess the capacity to make healthcare decisions:
Most of time ☐ Occasionally ☐ Sometimes ☐ Not at all ☐

Has patient taken an active role in his/her care (actively participates and/or provides direction?
Most of time ☐ Occasionally ☐ Sometimes ☐ Not at all ☐

Does the patient consent to care routines / treatment plans?
Most of time ☐ Occasionally ☐ Sometimes ☐ Not at all ☐

Does patient experience symptoms of anxiety?
Most of time ☐ Occasionally ☐ Sometimes ☐ Not at all ☐

Does patient experience symptoms of depression?
Most of time ☐ Occasionally ☐ Sometimes ☐ Not at all ☐

Has patient or family had any particular difficulty adjusting to patient's condition? Yes ☐ No ☐

If so, please describe:

NUTRITION:

What method of feeding is utilized?

Oral Feeds ☐ Gastrostomy ☐ Nasogastric ☐ Jejunostomy ☐

Diet:

Caloric Intake:

Present Weight: Ideal Weight: Pre-Admission Weight:

ELIMINATION:

Urinary System:

Is the patient continent of urine?: Yes ☐ No ☐

If no, specify:

Diapers ☐ Condom Catheter ☐ Indwelling Catheter ☐ Type _____ Last Change _____

Bowel:

Is the patient continent of bowel functioning? Yes ☐ No ☐

If no, please describe bowel routine (laxatives, enema, etc.) _____

Does patient use: BEDPAN ☐ DIAPERS ☐ COMMODE ☐

SKIN CONDITION:

Is there any skin breakdown **at present**: Yes ☐ No ☐ Date of Onset: _____

If yes, what area(s) are involved? _____
(include stage)

Current treatment:

Is patient at risk to develop skin breakdown? Yes ☐ No ☐

Is there a history of past skin breakdown? Yes ☐ No ☐

If yes, area(s) involved: _____

MUSCULOSKELETAL STATUS:

Does the patient have active ROM?	FUNCTIONAL	NON-FUNCTIONAL
a) of neck	☐	☐
b) of arms	☐	☐
c) of legs	☐	☐

Does the patient have passive ROM? Full _____ Limited _____

Please describe any:

a) Limitations/Contractions/Pain/Oedema: _____

b) Spasticity: _____

c) Orthopaedic Problems: _____

Intervention for above (splints, positioning, exercise):

ADL:

	Independent	Assistance Needed	Supervision	Dependent
Shaving	☐	☐	☐	☐
Oral Care	☐	☐	☐	☐
Grooming	☐	☐	☐	☐
Bathing/Washing	☐	☐	☐	☐
Feeding	☐	☐	☐	☐
Dressing	☐	☐	☐	☐

MOBILITY, TRANSFERS AND POSITIONING:

Is the patient ambulatory? Yes ☐ No ☐ How often?_____

Mobility Aids: _____

Has equipment been: Prescribed ☐ Ordered ☐

Does the patient require assistance for transfer? Yes ☐ No ☐ # of persons: _____

Manual Lift ☐ Mechanical Lift ☐ Manual Transfer ☐ Describe: _____

Can the patient shift his/her own weight in:

a) Chair Yes ☐ No ☐

b) Bed Yes ☐ No ☐

Does the patient have a special mattress? Yes ☐ No ☐

If yes, what type?

Does the patient use positioning devices? Yes ☐ No ☐

If yes, which type:

Does the patient tolerate changes in positions in bed? Yes ☐ No ☐

If yes, check all that apply:

Supine ☐ Right-side Lying ☐ Left-side Lying ☐

ACCESS TO ENVIRONMENT:

Can the patient activate call bell? Yes ☐ No ☐ If yes, what type? _____

List environmental controls currently used:

	Independent	Assistance	Dependant
Telephone	☐	☐	☐
TV/Stereo	☐	☐	☐
Computer	☐	☐	☐
Other	☐	☐	☐

SOCIAL SITUATION:

Please outline the patient's present family situation (i.e. marital status, siblings, offspring). Indicate extent of involvement of family and friends since patient became ventilated (i.e. visiting, outside activities, leisure activities)

HOME ENVIRONMENT/EQUIPMENT:
Is the home accessible? Please describe (# of levels, stairs, doorways, ramps):

MOBILITY/OTHER EQUIPMENT:	
Please describe any mobility/other equipment owned by the patient:	
☐ wheelchair/walker	☐ bathroom safety
☐ mechanical lift	☐ commode
☐ hospital bed	☐ specialty mattress
☐ ventilator/Bipap/Cpap	☐ portable suction unit
☐ diaphragmatic pacers	☐ apnea monitors
☐ manual resuscitators	☐ battery chargers
☐ low pressure alarms	☐ in/exsufflator

Name of Person Completing the Form **Title**

Signature of Person Completing the Form **Date**