WEST PARK HEALTHCARE CENTRE – CHRONIC ASSISTED VENTILATORY CARE

PRE-ASSESSMENT REFERRAL

Contact: Long-Term Ventilation Strategy Coordinator 416-243-3600 x2309; Fax: 416-243-8397

Please complete an electronic referral if you have access to the RM&R electronic referral system. 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 ☐

CONTACTS: (CONTACT PERSONS WHO ASSISTED IN THE COMPLETION OF THIS FORM)

DISCIPLINE	NAME	PHONE #
Physician		
Nursing		
Respiratory Therapist		
Occupational Therapist		
Physiotherapist		
Social Worker		
OTHER		
OTHER		

PATIENT GOALS:

What are the patient's short-term goals?

What are the patient's long-term goals?

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)

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:

RESPIRATORY EQUIPMENT:

Please list all patient owned respiratory equipment (i.e. ventilators, diaphragmatic pacers, antennae, cables, apnea monitors, battery charges, low pressure alarms, suction equipment, manual resuscitators, etc.):

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	☐	☐	☐	☐
Shower/Tub	☐	☐	☐	☐
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	☐	☐	☐

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	☐	in/exsufflator
☐	manual resuscitators	☐	battery chargers
☐	other	☐	other

Name of Person Completing the Form	**Title**
Signature of Person Completing the Form	**Date**

Patient / SDM has agreed to referral	☐ YES ☐ NO