WEST PARK HEALTHCARE CENTRE – CHRONIC ASSISTED VENTILATORY CARE

PRE-ASSESSMENT REFERRAL

CONTACT: Service Manager, 416-243-3600, Ext. 2050

This form is only to be completed once the patient's referral has been approved for pre-assessment and is requested by the CAVC team at West Park Healthcare Centre.

IN ENLISTING PATIENT/FAMILY TO COMPLETE THIS FORM, STAFF SHOULD BE AWARE THAT SOME QUESTIONS ARE OF A SENSITIVE NATURE.

PATIENT NAME: ______________________ ______________________

Surname First Name

BIRTH DATE: ____________ AGE: ________ SEX: ______ MARITAL STATUS: ____________

HEALTH CARD NUMBER:

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

ADDRESS:

PHONE:

REFERRING PHYSICIAN: PHONE:

PRIMARY DIAGNOSIS (please include date of onset):

RELEVANT CO-MORBIDITIES:

MEDICALLY STABLE: YES: ☐ NO: ☐

PROGNOSIS DISCUSSED WITH PATIENT: ☐ FAMILY: ☐

SUBSTITUTE DECISION MAKER:

POWER OF ATTORNEY for Healthcare Decisions:

POWER OF ATTORNEY for Financial Decisions:

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

ADVANCE CARE DIRECTIVES:

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

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? ______________________________

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	☐	☐
Judgment	☐	☐
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):

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 ☐

ADL:

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

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)

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