



**WEST PARK HEALTHCARE CENTRE
HOME VENTILATION TRAINING AND FOLLOW-UP
PRE-ASSESSMENT REFERRAL**

CONTACT: Respiratory Care Coordinator at 416-243-3600, Ext. 4765

In order for a patient to go home on a ventilator, an identified placement in the community including appropriate caregiver support when indicated must be a realistic option. Arrangements for this must be initiated prior to completing and submitting this referral form.

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

PATIENT NAME: _____

BIRTH DATE: _____ Surname _____ AGE: _____ SEX: _____ First Name _____ 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		

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 discharge location accessible? Yes No

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.

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: FiO₂ _____ Spontaneous _____ Ventilated: _____VALUES: PH _____ PO₂ _____ PCO₂ _____ HCO₃ _____ 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 ₂ O	PEEP _____ cmH ₂ O
R.R. _____ bpm	Pressure Support _____ cmH ₂ O
Recent ABG Results on the above settings: _____	

TRACHEOSTOMY:		
Trach Tube Type / Size: _____	CUFFED: <input type="checkbox"/>	UNCUFFED: <input type="checkbox"/>
	FENSTRATED: <input type="checkbox"/>	UNFENSTRATED: <input type="checkbox"/>
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 videofluoroscopy? _____

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 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 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 <input type="checkbox"/>	No <input type="checkbox"/>	Date of Onset: _____
If yes, what area(s) are involved? _____ (include stage)			
Current treatment:			
Is patient at risk to develop skin breakdown?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Is there a history of past skin breakdown?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, area(s) involved: _____			

MUSCULOSKELETAL STATUS:			
Does the patient have active ROM?		FUNCTIONAL	NON-FUNCTIONAL
a) of neck		<input type="checkbox"/>	<input type="checkbox"/>
b) of arms		<input type="checkbox"/>	<input type="checkbox"/>
c) of legs		<input type="checkbox"/>	<input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>	How often? _____
Mobility Aids:			
Has equipment been:	Prescribed <input type="checkbox"/>	Ordered <input type="checkbox"/>	
Does the patient require assistance for transfer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	# of persons: _____
Manual Lift <input type="checkbox"/>	Mechanical Lift <input type="checkbox"/>	Manual Transfer <input type="checkbox"/>	Describe: _____
Can the patient shift his/her own weight in:			
a) Chair	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
b) Bed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Does the patient have a special mattress?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, what type?			
Does the patient use positioning devices?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, which type:			
Does the patient tolerate changes in positions in bed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, check all that apply:			
Supine <input type="checkbox"/>	Right-side Lying <input type="checkbox"/>	Left-side Lying <input type="checkbox"/>	

MOBILITY/OTHER EQUIPMENT:

Please describe any mobility/other equipment owned by the patient:

 wheelchair/walker bathroom safety mechanical lift commode hospital bed specialty mattress

Name of Person Completing the Form

Title

Signature of Person Completing the Form

Date