**WEST PARK HEALTHCARE CENTRE**

**TRANSITIONAL HOME VENTILATION PROGRAM**

**PRE-ASSESSMENT REFERRAL**

| CONTACTS: | Raj Kohli, Coordinator 416-243-3600 ext. 2309; Fax 416-243-3739 |
|---|---|
| | Laura Watling, Manager 416-243-3600 ext. 2350; 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 |
|---|---|---|
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**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): |
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| 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 |
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|---|---|
| **Name of Person Completing the Form** | **Title** |
| **Signature of Person Completing the Form** | **Date** |