



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: FiO ₂ _____	Spontaneous _____	Ventilated: _____	
VALUES: PH _____	P0 ₂ _____	PCO ₂ _____	HCO 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 O₂ required while ventilated: _____

Is O₂ 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: UNCUFFED:
FENSTRATED: UNFENSTRATED:

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: <input type="checkbox"/>	NO: <input type="checkbox"/>	
What is the language spoken and understood by the patient?			
Does the patient require use of a communication device?	YES: <input type="checkbox"/>	NO: <input type="checkbox"/>	
If so, please specify (i.e. communication board, clipboard, mouthing words)			

COGNITIVE / EMOTIONAL:						
Is the patient alert?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Oriented to:	Time <input type="checkbox"/>	Person <input type="checkbox"/>	Place <input type="checkbox"/>
	Intact		Impaired			
Memory	<input type="checkbox"/>			<input type="checkbox"/>		
Judgement	<input type="checkbox"/>			<input type="checkbox"/>		
Insight	<input type="checkbox"/>			<input type="checkbox"/>		
Does the patient possess the capacity to make healthcare decisions:						
	Most of time <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Not at all <input type="checkbox"/>		
Has patient taken an active role in his/her care (actively participates and/or provides direction?)						
	Most of time <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Not at all <input type="checkbox"/>		
Does the patient consent to care routines / treatment plans?						
	Most of time <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Not at all <input type="checkbox"/>		
Does patient experience symptoms of anxiety?						
	Most of time <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Not at all <input type="checkbox"/>		
Does patient experience symptoms of depression?						
	Most of time <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Not at all <input type="checkbox"/>		
Has patient or family had any particular difficulty adjusting to patient's condition? Yes <input type="checkbox"/> No <input type="checkbox"/>						
If so, please describe:						

NUTRITION:			
What method of feeding is utilized?			
Oral Feeds <input type="checkbox"/>	Gastrostomy <input type="checkbox"/>	Nasogastric <input type="checkbox"/>	Jejunostomy <input type="checkbox"/>
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 COMMUNE **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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing/Washing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shower/Tub	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TV/Stereo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MOBILITY/OTHER EQUIPMENT:

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

<input type="checkbox"/> wheelchair/walker	<input type="checkbox"/> bathroom safety
<input type="checkbox"/> mechanical lift	<input type="checkbox"/> commode
<input type="checkbox"/> hospital bed	<input type="checkbox"/> specialty mattress
<input type="checkbox"/> ventilator/Bipap/Cpap	<input type="checkbox"/> portable suction unit
<input type="checkbox"/> diaphragmatic pacers	<input type="checkbox"/> in/exsufflator
<input type="checkbox"/> manual resuscitators	<input type="checkbox"/> battery chargers
<input type="checkbox"/> other	<input type="checkbox"/> other

Name of Person Completing the Form _____

Title _____

Signature of Person Completing the Form _____

Date _____

Patient / SDM has agreed to referral

YES NO