



**WEST PARK HEALTHCARE CENTRE  
TRANSITIONAL HOME VENTILATION PROGRAM  
PRE-ASSESSMENT REFERRAL**

CONTACTS: Raj Kohli, Coordinator 416-243-3600 ext. 2309; Fax 416-243-8397

**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:



**VENTILATOR SETTINGS:**

Current Ventilator Model: \_\_\_\_\_

Mode of Ventilation: \_\_\_\_\_

$V_T$	_____	c.c.	$FiO_2$	_____	
Pressure Control	_____	cmH <sub>2</sub> O	PEEP	_____	cmH <sub>2</sub> O
R.R.	_____	bpm	Pressure Support	_____	cmH <sub>2</sub> 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: \_\_\_\_\_

**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  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  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	<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): \_\_\_\_\_

**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"/>
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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"/>

**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):


**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"/> apnea monitors
<input type="checkbox"/> manual resuscitators	<input type="checkbox"/> battery chargers
<input type="checkbox"/> low pressure alarms	<input type="checkbox"/> in/exsufflator

_____ <b>Name of Person Completing the Form</b>	_____ <b>Title</b>
_____ <b>Signature of Person Completing the Form</b>	_____ <b>Date</b>
<b>Patient / SDM has agreed to referral</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO