



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

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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 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: _____

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"/> |

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:

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