

ADDRESS:

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

CONTACTS: Raj Kohli, Coordinator 416-243-3600 ext. 2309; 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: First Name Surname **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: RFI ATIONSHIP: 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:

PHONE NUMBER:

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?				
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				

ACCOMMODATION REQUESTED: STANDARD SEMI-PRIVATE PRIVATE

Oth	ner:		

CURRENT LAB RES	ULTS:				
Hgb	K		BUN	Ca	
Wbc	Na		CR	Alb	
HcT				Glob	
MRSA	Date			PT	
VRE	Date			PTT	
C-Diff	Date		V (1)		
ABG's: Fi0 ₂	Spontaneou	s	ventilated:		
VALUES: PH	P0 ₂	PCO ₂ _	HC0 ₃	Date:	
MEDICATIONS (attac	ch list if more sp	ace is need	ed):		
Medica			Dosage	Frequency	
VENTILATION NEED)S:				
Ventilation Start Date:					
How many hours/day i mechanical ventilation					
Vent-free time:					
Is O ₂ required while ve	ntilated:				
Is O ₂ required while patient is breathing spontaneously?					

VENTILATOR SE	TTINGS:				
Current Ventilator I	Model:				
Mode of Ventilation	n:				
V_T		C.C.	FiO ₂		
Pressure Control		cmH ₂ O	PEEP	cmH ₂ O	
R.R.		bpm	Pressure Support	cmH₂O	
Recent ABG Resul	ts on the above s	ettings:			
TRACHEOSTOM	Y :	•			
Trach Tube Type /		CUFFED		D: 🗌	
	F	ENSTRATED	: UNFENESTRATED	D: 🗌	
If cuffed, cuff volun	ne:				
Date of recent Trac	ch Tube Change:				
Trach Changes Pe	rformed By (i.e. P	hysician, RRT)	:		
Frequency of Track	n Changes:				
Stoma Condition:					
If patient has vent-	free time, is patier	nt able to tolera	te cuff deflation or corking?	?	
DIAPHRAGMATIC	C PACING:				
Model:					
Bilateral Pacing?		Ur	nilateral Pacing?		
Resp. Rate:	bpm	Right Ampl.:	Left Ampl.:	:	
		-			
How long patient u	ses pacers?:		Hrs/24 hrs	:	
CUCTIONING:			·	<u> </u>	
SUCTIONING:					
Frequency:	to outsion colf?				
Is the patient able					
Has the patient had a swallowing assessment, including videofluroscopy?					
Does patient have a problem with aspiration? YES: NO:					
If Yes, please describe:					
MANUAL VENITL	ATION:				
How often is patier	nt 'bagged'?				
When is patient us	ually 'bagged'?				
Can patient 'bag' h	im/herself?				
Additional COMME	NTS:				

COMMUNICATION:				
Is the patient able to speak?	YES:	NO:		
What it is the language spoken a	and understood by the	patient?		
Does the patient require use of a	a communication device	ce? YES:	NO	D: 🗌
If so, please specify (i.e. commu	nication board, clipboa	ard, mouthing words)		
COGNITIVE / EMOTIONAL:				
Is the patient alert? Yes	No Orient	ed to: Time	Person _	Place _
_	Intact	Impaired		
Memory	П			
Judgement				
Insight				
_	unnacity ta maka baal	theore decisions.		
Does the patient possess the c	Most of time	Occasionally	Sometimes	Not at all
Has patient taken an active role	e in his/her care (activ	vely participates and/o	or provides directio	 n?
·	Most of time	Occasionally	Sometimes	Not at all
Does the patient consent to ca	_	• —	_	_
'	Most of time	Occasionally	Sometimes	Not at all
Does patient experience symptom	_	, L		
, , , , , , , , , , , , , , , , , , , ,	Most of time	Occasionally	Sometimes	Not at all
Does patient experience symptom	_			
	Most of time □	Occasionally	Sometimes	Not at all
	<u>—</u>	• —	_	
Has patient or family had any p	particular difficulty adj	usting to patient's con	dition? Yes	No 🔛
If so, please describe:				
AULTDITION				
NUTRITION:	70d?			
What method of feeding is utilized Oral Feeds	Sastrostomy	Nasogastric	Jejunostomy [
Diet:	, —		, , , , ,	
Caloric Intake:				
Present Weight:	Ideal Weight:		Pre-Admission W	eiaht:
i iosciii vvoigiii.	ideal vveigili.		TIC AGIII33IOH W	oigiit.
п				

ELIMINATION:				
Urinary System:				
Is the patient continent of If no, specify:	f urine?: Yes	□ No □		
Diapers Condon	n Catheter 🗌 Indw	relling Catheter 🗌 Typ	е	Last Change
Bowel: Is the patient continent or	f bowel functioning?	Ye	s 🗌	No 🗌
If no, please describe bo	wel routine (laxative	s, enema, etc.)		
Does patient use:	BEDPAN 🗌	DIAPERS 🗌	COMMO	DE 🗌
SKIN CONDITION:				
Is there any skin breakdo	own at present :	Yes 🗌 No 🗌 🛚 🗈	Date of Onset:	
If yes, what area(s) are in (include stage)	nvolved?			
Current treatment:				
Is patient at risk to develor Is there a history of past		Yes No		
If yes, area(s) involved:	Skiii bieakdowii:	163 🔲 110		
MUSCULOSKELETAL S	PATHE:			
MUSCULOSKELETAL S Does the patient have ac		FUNCTIONA	AL NO	ON-FUNCTIONAL
Does the patient have ac	tive ROM?	FUNCTIONA	AL NO	ON-FUNCTIONAL
Does the patient have ac		FUNCTIONA	AL N	ON-FUNCTIONAL
Does the patient have ac a) b)	tive ROM? of neck	FUNCTIONA	AL N	ON-FUNCTIONAL
Does the patient have ac a) b) c) Does the patient have pa	ctive ROM? of neck of arms of legs	FUNCTIONA	Limited	ON-FUNCTIONAL
Does the patient have ac a) b) c)	ctive ROM? of neck of arms of legs assive ROM?			ON-FUNCTIONAL
Does the patient have ac a) b) c) Does the patient have pa Please describe any:	ctive ROM? of neck of arms of legs assive ROM?			ON-FUNCTIONAL
Does the patient have act a) b) c) Does the patient have act and because have act	of neck of arms of legs assive ROM? ions/Pain/Oedema:			ON-FUNCTIONAL
Does the patient have act a) b) c) c) Does the patient have particular please describe any: a) Limitations/Contractions/Co	of neck of arms of legs assive ROM? ions/Pain/Oedema:	Full		ON-FUNCTIONAL
Does the patient have act a) b) c) Does the patient have particle and patients.	of neck of arms of legs assive ROM? ions/Pain/Oedema:	Full		ON-FUNCTIONAL
Does the patient have act a) b) c) c) Does the patient have particular please describe any: a) Limitations/Contractions/Co	of neck of arms of legs assive ROM? ions/Pain/Oedema:	Full		ON-FUNCTIONAL
Does the patient have act a) b) c) Does the patient have pare Please describe any: a) Limitations/Contraction b) Spasticity: c) Orthopaedic Problem Intervention for above (spanning patients)	etive ROM? of neck of arms of legs assive ROM? ions/Pain/Oedema: ms: olints, positioning, ex	Full		ON-FUNCTIONAL
Does the patient have act a) b) c) Does the patient have pare Please describe any: a) Limitations/Contraction b) Spasticity: c) Orthopaedic Problem Intervention for above (spanning)	etive ROM? of neck of arms of legs assive ROM? ions/Pain/Oedema: ms: olints, positioning, ex	Full	_ Limited _	
Does the patient have act a) b) c) Does the patient have pare Please describe any: a) Limitations/Contraction b) Spasticity: c) Orthopaedic Problem Intervention for above (spanning Oral Care	etive ROM? of neck of arms of legs assive ROM? ions/Pain/Oedema: ms: olints, positioning, ex	Full	_ Limited _	
Does the patient have act a) b) c) Does the patient have pare Please describe any: a) Limitations/Contraction b) Spasticity: c) Orthopaedic Problem Intervention for above (spanning)	etive ROM? of neck of arms of legs assive ROM? ions/Pain/Oedema: ms: olints, positioning, ex	Full	_ Limited _	
Does the patient have act a) b) c) Does the patient have pare Please describe any: a) Limitations/Contraction b) Spasticity: c) Orthopaedic Problem Intervention for above (spanning Oral Care	etive ROM? of neck of arms of legs assive ROM? ions/Pain/Oedema: ms: olints, positioning, ex	Full	_ Limited _	
Does the patient have act a) b) c) Does the patient have pare Please describe any: a) Limitations/Contraction b) Spasticity: c) Orthopaedic Problem Intervention for above (spanning) ADL: Shaving Oral Care Grooming	etive ROM? of neck of arms of legs assive ROM? ions/Pain/Oedema: ms: olints, positioning, ex	Full	_ Limited _	

WODILITT, TRANSFE	RS AND POSITION	ING:		
Is the patient ambulate Mobility Aids:	ory? Yes 🗌	No 🗌	How ofte	en?
Has equipment been:	Preso	cribed	Ordered	
Does the patient requi	re assistance for tran	sfer? Yes	No 🗌	# of persons:
Manual Lift	Mechanical Lift	Manual Transfer	Describe:	
Can the patient shift hi	is/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 parties of the patient use parties of the patient tolers of the patient that appear to the patient of the patient use patient of the patient use patient of the patie	ate changes in positio	│Yes ☐ ons in bed? │Yes ☐ ☐ Left-side Lyir	No	
ACCESS TO ENVIRO				
Can the patient activate List environmental cor			s, what type' sistance	? Dependant
	macpon	, , ,	olotal loo	D op on a and
Telephone		, id		
Telephone TV/Stereo		7.6		
•				
TV/Stereo				
TV/Stereo Computer Other				
TV/Stereo Computer Other SOCIAL SITUATION:				
TV/Stereo Computer Other SOCIAL SITUATION: Please outline the patie	ent's present family situ			spring). Indicate extent of
TV/Stereo Computer Other SOCIAL SITUATION: Please outline the patie involvement of family at	ent's present family situ	uation (i.e. marital status		spring). Indicate extent of
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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 pat	ient:			
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			
	<u>'</u>				
Name of Person Completing the Form		Title			
Name of Ferson completing the Form		THE			
Signature of Person Completing the Form		Date			
Patient / SDM has agreed to referral		☐ YES ☐ NO			