West Park HEALTHCARE CENTRE

LTV Application

LABEL

LTV Application

Please fax a filled form to: LTV referral - 416-243-3739 ATTEN: LTV COORDINATOR

DEMOGRAPHICS

Patient's First Name: _____ Patient's Last Name: _____

Patient's Home Address: _____ City: _____ Postal code: _____

Patient's Phone Number: _____

☐ Male ☐ Female ☐ Other: _____ Marital Status: _____

DOB (YYYY-MM-DD) _____ yyyy/mm/dd Age: _____

Health Card: _____ Version Code: _____ Expiry Date: _____ yyyy/mm/dd

Languages Spoken: _____ Translator Needed (Y/N) _____

Emergency Contact Information: Name: _____

Relationship: _____ Phone: _____

APPLICATION IS FOR (please check one):

LONG TERM VENTILATION ☐ TRANSITION TO HOME PROGRAM ☐

FACILITY INFORMATION

Referring Facility: _____

Date of Admission (YYYY-MM-DD): _____ yyyy/mm/dd Attending Physician: _____

Bed Offer Contact: _____

Phone: _____ Fax: _____

Email: _____ Date Referral completed (YYYY-MM-DD): _____ yyyy/mm/dd

IPAC

☐ Isolation status (please specify site, source and organisms)

_____

_____

PRE-CRITICAL ILLNESS PHYSICAL HEALTH STATUS

☐ Working within/outside the home and functionally independent

☐ Not working within/outside the home and functionally independent for ADLs

☐ Requiring some assistance/devices with ADLs

☐ Fully Dependent for ADLs

☐ ICU Admitting Diagnosis: _____

☐ ICU Length of Stay (days): _____

☐ Complications within ICU: _____

Neurological

LOC: _____

Unresponsive vs alert: _____

Ability to communicate, please specify: _____

Documented Advance Care Plan/Goals of Care discussion _____

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Respiratory

Must be Stable on ventilator settings for 15 days prior to transfer/Fi-02 < 0.4 on/off the ventilator.

Mechanical Ventilation (MV) Duration (days): _____

Current MV settings: _____

TM wean schedule: _____

Date of Tracheostomy (YYYY-MM-DD): _____ yyyy/mm/dd

Current Trach Specifications: _____

Any Tracheostomy/airway complications: ☐ No ☐ Yes, please specify: _____

Any trails of cuff deflation? ☐ No ☐ Yes, please specify: _____

Any trials of cough assist / LVR ☐ No ☐ Yes, please specify: _____

Any trails of speaking valve ☐ No ☐ Yes, please specify: _____

Tracheal suctioning frequency (not to exceed q2-3 hours): _____

Cardiovascular

No major cardiac events 30 days prior to transfer.

☐ Stable/Rhythm _____

☐ Last day of pressors (No pressor/inotrope use 30 days prior to transfer): _____

☐ Is patient on midodrine and how frequent? _____

☐ Does the patient have IV access: If yes, specify: _____

Gastrointestinal

TPN and NG/OG tubes are not supported, ensure a patient has G/J/PEG tube prior to being admitted

Appliance type, size and location (G/J/PEG): _____

Date of G-tube insertion (YYYY-MM-DD): _____

Feed type and rate _____

PO Diet (if any) _____

Patient's height and weight _____

Genitourinary

☐ Continent/Independent (any comments): _____

☐ Foley in situ (type/ size): _____

PREVIOUS FUNCTIONAL STATUS & SOCIAL HISTORY

Describe Level of Function Prior to Hospital Admission (BADL, IADL, functional status, gait aid):

Previous Community Supports: _____

Accommodation Barriers: _____

Any specialized equipment (i.e. personal custom wheelchair): _____

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C1395

West Park
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CURRENT FUNCTIONAL STATUS

Patient goals: _____

Participation level: _____ hours/day _____ sessions/day _____

Sitting tolerance: _____ Does patient transfer to chair daily? ☐ Yes ☐ No

Weight bearing status: _____

Activity	*Independent*	*Supervision*	*Ax1*	*Ax2*	*Dependent*
Bed Mobility (e.g. turning)	☐	☐	☐	☐	☐
Transfers	☐	☐	☐	☐	☐
Ambulation	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐

Please attach the following notes:

- ☐ **Latest physician note including medical and surgical history**
- ☐ **MAR**
- ☐ **Last IPAC note**
- ☐ **OT/PT notes**
- ☐ **RD notes**
- ☐ **Wound Care Notes**
- ☐ **Social worker notes including the last Family Meeting notes (Advance Care Plan/Goals of Care discussion) within 48hrs prior to transfer**

*Please note, if the requested notes are missing, the applications' time will be delayed.

*A co-payment may be required for a LTV bed, which will be determined by the finance department