LONG TERM VENTILATION PROGRAM PLACEMENT FORM

Grace
Toronto Grace Health Centre

DEMOGRAPHICS

Patient's first name: _____ Last name: _____

Patient's Home Address: _____

Sex ☐ Male ☐ Female DOB (YYYY-MM-DD)_____

FACILITY INFORMATION

Referral facility _____

Date of Admission (YYYY-MM-DD) _____ Attending Physician _____

Bed Offer Contact _____ Phone: _____ Fax: _____

Primary Contact ☐ Same as above. If different, specify: _____

Date Referral Completed (YYYY-MM-DD) _____

POWER of ATTORNEY for PERSONAL CARE (1) AND FINANCES (2)

(1) First name: _____ Last name: _____.

Preferred means of communication: (H) _____ (C) _____

Email: _____ Fax Number: _____

(2) First name: Last name:

Preferred means of communication: (H) _____ (C) _____

Email: _____ Fax Number: _____

Copy of paperwork available (1) ☐Yes ☐No (2) ☐Yes ☐No

Please fax a copy of this form along with a face sheet to:
Michelle McDonell, The Salvation Army Toronto Grace Health Centre 416-925-0939

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RESUSCITATION CARE DIRECTIVES

CODE STATUS: _____

Prognosis of Patient: _____

Prognosis discussed with: Patient ☐ yes ☐ no With SDM /POA ☐ yes ☐ no

Philosophy of Care:☐ Curative ☐ Palliative

Discussed with Patient ☐ yes ☐ no With SDM /POA ☐ yes ☐ no

Comments:

_____

Goals – Short term

_____

Goals – Long term

_____

Past Medical History:

_____

Mental Health History:

_____

Allergies & Adverse Drug Reactions:

_____

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Past Surgical History:

_____

Vaccination List

Date of last Influenza Vaccination: _____

Date of last Pneumovax Vaccination: _____

Date of last Tetanus Vaccination: _____

Medication List - please attach to referral ☐Attached

SOCIAL SITUATION & FAMILY:

Please outline the patient's present family situation (i.e. marital status, siblings, offspring) and financial situation/source of income.

_____

Has patient or family had any particular difficulty adjusting to patient's condition? ☐Yes ☐No

If yes, please describe: _____

COGNITIVE/EMOTIONAL:

Is the patient alert: ☐Yes ☐ No

Oriented To: ☐Time ☐Person ☐Place

	Intact	Impaired
Memory	☐	☐
Judgement	☐	☐
Insight	☐	☐

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	Most of the time	Occasionally	Sometimes	Not at all
Does the patient possess the capacity to make healthcare decisions?	☐	☐	☐	☐
Has patient taken an active role in their care?	☐	☐	☐	☐
Dose the patient consent to care routines/treatment plans?	☐	☐	☐	☐
Does the patient experience symptoms of anxiety?	☐	☐	☐	☐
Does the patient experience symptoms of depression?	☐	☐	☐	☐
Does the patient actively participate and/or provide direction in their care?	☐	☐	☐	☐
Is the patient cooperative?	☐	☐	☐	☐
Does the patient actively participate and/or provide direction in their care?	☐	☐	☐	☐

SWALLOWING & NUTRITION:

Swallowing Deficit: ☐Yes ☐No Swallowing Assessment Completed: ☐Yes ☐No
Videofluroscopy ☐Yes ☐No If Yes to any, p*lease attach a SLP Assessment*

Oral Diet ☐Yes ☐No (NPO – Leave following sections blank)
Diet texture: ☐Regular ☐Soft (No hard fruits/vegetables) ☐Minced ☐Pureed
Fluid Consistency: ☐Regular ☐Mildly thick (Nectar) ☐Moderately Thick (Honey)
☐Extremely Thick (Pudding)
Diet (Therapeutic): ☐Regular ☐Diabetic ☐Heart Healthy ☐Renal ☐Vegetarian
☐Other, specify: _____

Enteral Feeds ☐Yes ☐No ☐G-Tube ☐GJ-Tube ☐J-Tube (Tube size Click here to enter text.)
Specify formula type, dose, rate, frequency & administration time(s): _____
Water flush protocol: _____

Patient current weight: _____ Usual weight: _____
Height: _____

Allergies: _____

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RESPIRATORY THERAPY

Tracheostomy: ☐Yes ☐No Type: _____ Size: _____

Date of recent trach tube change: _____

Frequency of trach change: _____ Performed by: _____

Stoma condition ☐Granuloma ☐Stenosis ☐Infection

Comments: _____

If patient has vent free time, is patient able to tolerate cuff deflation or corking? ☐Yes ☐No

SUCTIONING

Frequency: _____

Is the patient able to self-suction? ☐Yes ☐No

Does the patient have a problem with aspiration? If Yes, please describe _____

VENTILATION

☐Invasive ☐ Non-invasive Mask type/size: _____

When was ventilation started? _____

How long patient is ventilated? _____

Hours/24 hours _____ hrs/24 hr Nocturnal Schedule: _____

Date of last change in ventilator setting? _____ What changed and why:

State of ventilator requirements: _____

How long can a spontaneous breathing be maintained? _____

Does patient use supplemental oxygen? ☐Yes ☐No Flow rate: _____

How often is patient usually "bagged"? _____

Can patient bag themselves? ☐Yes ☐No

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CURRENT VENTILATOR SETTINGS:

Current Ventilator Model: _____ Mode of Ventilation: _____
Other: _____

Type of Ventilation: _____

VOLUME _____ PRESSURE _____

Trach Cuff: When is cuff deflated? ☐ NEVER ☐ YES, please describe _____

FiO2: _____ Other: _____ %

Tidal Volume: _____ Other: _____ mL

Respiratory Rate: _____ Other: _____ bpm

Pressure Support: _____ Other: _____ cmH2O

Pressure Control: _____ Other: _____ cmH2O

Inspiratory Time: _____ Other: _____ sec

PEEP/CPAP: _____ cmH2O used for WOB _____

or Oxygenation _____

Peak Inspiratory Pressure range: _____

Mean Airway Pressure range: _____

Sensitivity: Pressure: _____ Other: _____ or Flow:
Other: _____

Humidification Methods: _____

Comments: _____

DIAPHRAGMATIC PACING:

Model: _____

Bilateral Pacing? _____ Unilateral Pacing? _____

Resp. Rate: _____ bpm

Right Ampl. _____ Left Ampl. _____

How long patient uses pacers? _____ Hrs/day.: _____

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OCCUPATIONAL & PHYSICAL THERAPY

Hearing: ☐ Intact ☐Reduced Hearing Aid: ☐ Lt ☐ Rt
Vision: ☐Intact ☐Reduced ☐ Lt ☐ Rt ☐ Completely Impaired ☐ Glasses

ACCESS TO ENVIRONMENT
Can the patient activate call bell? ☐Yes ☐No
If yes, what type? _____
List environmental controls currently used: _____

	Independent	Assistance	Dependent
Telephone	☐	☐	☐
TV/Stereo	☐	☐	☐
Computer	☐	☐	☐

Other: _____

MOBILITY/OTHER EQUIPMENT
Wheelchair ☐Yes ☐No
Mechanical lift ☐Yes ☐No
Hospital bed ☐Yes ☐No
Ventilator/Bipap/Cpap ☐Yes ☐No
Diaphragmatic pacers ☐Yes ☐No
Manual resuscitators ☐Yes ☐No
Commode ☐Yes ☐No
Specialty mattress ☐Yes ☐No
Portable suction unit ☐Yes ☐No
In/exsufflator ☐Yes ☐No
Battery chargers ☐Yes ☐No
Other/Comments: _____
Any special surfaces, including bed? _____

FUNCTIONAL STATUS

Patient goals: _____
Participation level: _____ hours/day _____ sessions/day
Sitting tolerance: _____
Weight bearing status: _____

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Activity	Independent	Supervision	Ax1	Ax2	Dependent
Transfers	☐	☐	☐	☐	☐ (Mechanical lift)
Ambulation	☐	☐	☐	☐	☐
Bed Mobility (e.g. turning)	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐
Grooming	☐	☐	☐	☐	☐
Dressing (upper body)	☐	☐	☐	☐	☐
Dressing (lower body	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐

FALLS:

Does patient have history of falls? ☐Yes ☐No

If YES: ☐At home ☐Hospital ☐ Rarely ☐ Intermittently ☐Frequently

If YES, reason: ☐ Balance ☐ Strength ☐ Judgement/insight ☐ Fatigue ☐ Vision

☐ Other _____

NURSING

Does patient transfer to chair daily? ☐Yes ☐No

Use of restraints? ☐ Yes ☐ No

Is patient: ☐ Continent urine ☐ Continent bowel ☐ Incontinent urine ☐ Incontinent bowel

Ostomy: ☐Yes ☐No Type/brand and products: _____

Ability to care for ostomy? ☐Yes ☐No

PICC in place ☐Yes ☐No In use ☐Yes ☐No

IV Therapy: ☐Yes ☐No If Yes, please specify _____

Pain Management: Please describe _____

SKIN & WOUNDS

Surgical wounds and or ulcers: ☐Yes ☐No (Skin intact) If yes, complete the following

(If additional wounds exist, add supplementary information on a separate sheet of paper)

Location	Wound Type & Stage	Dressing Type (e.g. primary dressing, NPWT)	Frequency

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ADDITIONAL QUESTIONS:

1. What was/were care issues raised by the family in the past 6-12 weeks?

_____

2. What are the most significant care issues for this patient during their admission?

_____

3. Any other information you think that would be helpful?

_____

Please attach daily patient care plan, kardex/face sheet, daily routines, lab results, imaging reports

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