MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

CCC Chronic Ventilation Program Placement Assessment Form

In order to facilitate the assessment, and prompt processing of the application, it is imperative that this pre-assessment form be filled out accurately and a typed clinical/medical referral be included with this form. (Please include history of present illness, past medical history and ongoing medical issues.) **Submit completed referral to fax # 416-469-6864**

DEMOGRAPHICS

Patient's first name	**Last name**
Patient's Home Address	
Sex □ M □ F	**DOB** (YYYY-MM-DD)
Admission date to current facility (YYYY-MM-DD)	**Attending Physician**
Referring facility	
Bed Offer Contact (name and number/pager)	**Fax number**
Primary Contact □ Same as above. If different, specify name, number/pager and fax number.	
Date Referral Completed (YYYY-MM-DD)	

POWER of ATTORNEY for PERSONAL CARE or Substitute Decision Maker(s)

First name	**Last name**
Copy of Paperwork Available □	**Preferred Means of Communication:**
Home Phone:	**Work Phone:**
Fax Number:	**Email:**

POWER of ATTORNEY for FINANCES (if different from above)

First name	**Last name**
Copy of Paperwork Available □	**Preferred Means of Communication:**
Home Phone:	**Work Phone:**
Fax Number:	**Email:**

RESUSCITATION CARE DIRECTIVES

Past Medical History:

Prognosis of Patient:		
Prognosis discussed with: Patient □ yes □ no	**With SDM /POA □ yes □ no**	
Code Status:	**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 of Care – Short term

Goals of Care – Long term

Past Surgical History:
Psychiatric History:

PAST MEDICAL HISTORY

INTERDISCIPLINARY ASSESSMENTS

Medication List-please attach to referral
Allergy / Adverse Drug Reactions
Vaccination List Date of last Influenza Vaccination: Date of last Pneumovax Vaccination: Date of last Tetanus Vaccination:

Social Work

SOCIAL SITUATION:

Please outline the patient's present family situation (i.e. marital status, siblings, offspring).

_____
_____
_____
_____
_____
_____

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 the time ☐ Occasionally ☐ Sometimes ☐ Not at all ☐

Has patient taken an active role in his/her care (actively participates and/or provides direction)?
Most of the time ☐ Occasionally ☐ Sometimes ☐ Not at all ☐

Does the patient consent to care routines/treatment plans?
Most of the time ☐ Occasionally ☐ Sometimes ☐ Not at all ☐

Does the patient experience symptoms of anxiety?
Most of the time ☐ Occasionally ☐ Sometimes ☐ Not at all ☐

Does the patient experience symptoms of depression?
Most of the time ☐ Occasionally ☐ Sometimes ☐ Not at all ☐

Identify patient status prior to chronic ventilation (e.g. hobbies & interests, activities, personality, etc.)

_____
_____
_____

BEHAVIOUR: ***(If a Behaviour Plan is in place, please ATTACH).***

Is the patient anxious? Most of the time ☐ occasionally ☐ sometimes ☐ not at all ☐

Is the patient cooperative? Most of the time ☐ occasionally ☐ sometimes ☐ not at all ☐

Does the patient actively participate and/or provide direction in their care?
Most of the time ☐ occasionally ☐ sometimes ☐ not at all ☐

Use of restraints**:** Yes☐ No☐

FINANCIAL RESOURCES/COMMUNITY SUPPORTS:

FAMILY SUPPORTS:

Has patient or family had any particular difficulty adjusting to patient's condition? Yes ☐ No ☐
If yes, please describe:

_____
_____
_____
_____
_____
_____

Does the family understand the care needs of the patient? Yes ☐ No ☐

Indicate involvement of family and friends since patient became ventilated (ie. Visiting, outside activities, assistance in care routines where permitted.

_____
_____
_____

Please list any financial resources available, including the sources & contact information as appropriate (e.g. pensions, private disability insurance, health and/or disability benefits – CCP, ODSP)

Please list any additional resources available (e.g. CCAC, Community Agencies / Societies, Charities, Churches & Community Groups or Associations)

Speech Language Pathologist

COMMUNICATION: ***(Please attach a SLP Assessment if completed)***

Is patient able to communicate with care team? Yes □ No □

Does the patient? Speak □ Mouth words □

Does the patient use augmentative communication devices □ - Please describe:

_____
_____
_____

What languages are understood and spoken by patient?

_____
_____
_____

Does the patient use the standard call bell appropriately? - Yes □ No □

Please describe any assistive devices that have been used to support this patient -

_____
_____
_____
_____
_____
_____

SWALLOWING: *(Please attach a SLP Assessment if completed)*

Is the patient able to swallow? Yes □ No □ If yes, describe dietary textures

Dietician

Feeds by Mouth □ G/GJ/J Tube □ Combination □

Patient weight:_____

Type of Feed _____ Frequency:_____

Feeding intolerance (adverse reactions) _____

RESPIRATORY THERAPIST

TRACHEOSTOMY:

Trach Tube Type:_____ Size:_____

CUFFED □
FENESTRATED □

UNCUFFED □
UNFENESTRATED □

If cuffed, cuffed volume:_____

Date of recent Trach Tube Change:_____

Frequency of Trach Changes:_____

Stoma Condition:_____

Granulomas: _____
Stenosis:_____
Stoma infections:_____

Trach Changes Performed By (i.e. Physician, RRT):

_____

If patient has vent-free time, is patient able to tolerate cuff deflation or corking?: Y/N

SUCTIONING:

Frequency:_____
Is the patient able to suctions self?:_____
Has the patient had a swallowing assessment, including videofluroscopy?:_____
Does patient have a problem with aspiration? Yes □ No □…If Yes, Please describe:_____

VENTILATION:

Invasive: □ yes □ no Non-invasive: □ yes Mask type/size: _____ □ no
When was ventilation started? _____
How long patient is ventilated (hrs/24hrs)?
_____ Hours/24 hours _____Nocturnal Schedule_____
Date of last change in ventilator setting? _____
What changed? _____Why? _____
State of ventilator requirements: _____
How long can a spontaneous breathing be maintained? _____
Does the patient use supplemental oxygen? □ yes flow rate/FiO2_____ □ no
How often is patient "bagged"? _____ Is supplemental O2 used? □ yes □ no
When the patient is usually "bagged"? _____
Can patient "bag" her/himself? □ yes □ no

ALL VENTILATOR SETTINGS USED:

Current Ventilator Model: _____
Mode of Ventilation: _____ Other: _____
Type of Ventilation: Volume: □ or Pressure: □
Trach.Cuff: When is the cuff deflated? Never □or yes □: then 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.:_____

OCCUPATIONAL THERAPIST

ACCESS TO ENVIRONMENT

Can the patient activate call bell? Yes □ No □ If yes, what type?:_____

List environmental controls currently used:

	Independent	Assistance	Dependant
Telephone	□	□	□
TV/Stereo	□	□	□
Compute	□	□	□
Other	□	□	□

MOBILITY/OTHER EQUIPMENT

Please describe any mobility/other equipment owned by the patient:

- ☐ wheelchair
- ☐ mechanical lift
- ☐ hospital bed
- ☐ ventilator/Bipap/Cpap
- ☐ diaphragmatic pacers
- ☐ manual resuscitators
- ☐ other
- ☐ commode
- ☐ specialty mattress
- ☐ portable suction unit
- ☐ in/exsufflator
- ☐ battery chargers

NURSING

Does this patient transfer to chair daily? Yes ☐ No ☐

How many care givers needed for transfer? ___ Yes ☐ No ☐

Independent with turning in bed? Yes ☐ No ☐

How often is suctioning required? _____ Yes ☐ No ☐

Requires assistance with feeding? Yes ☐ No ☐

Special surfaces including bed surfaces? Yes ☐ No ☐
If yes, describe: _____
Patients own? _____

Ulcers: Yes ☐ No ☐
If yes, describe location and staging:_____

Why does this client need RN care?

What are limitations for RPN care?

Please attach daily patient care plan/daily routines:_____

ADDITIONAL QUESTIONS

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

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

3. Is a copy of the current care plan available? If so, please provide one.