

Provincial Long-Stay ICU and Weaning Programs Screening Tool



Use this screening tool for **all Provincial Mechanical Ventilation Weaning Programs** including:

- **Long Stay Critical Care program (LSP)** at Mackenzie Health. LongStay@MackenzieHealth.ca
- **Long Stay Critical Care program (LSP)** and the **Provincial Progressive Weaning Centre of Excellence (PWC)** at Michael Garron Hospital. Prolonged.ventilation@tehn.ca
- MGH will determine which program, LSP or PWC, is best for your patient

All Provincial Mechanical Ventilation Weaning Programs are subject to the Ontario Health directive regarding repatriation of patients when needed.

Criteria	True
ICU & Respiratory Supports	
Patient is ≥ 18 years of age and is currently admitted to a Level 3 ICU in Ontario.	
Patient's ICU length of stay is ≥ 10 days with reasonable evidence of needing a much longer ICU length of stay.	
Patient requires daytime invasive or non-invasive ventilation (CPAP, BiPAP), or high flow oxygen at least part of the day.	
Patient has the potential for liberation from invasive mechanical ventilation & is not anticipated to require long term mechanical ventilation indefinitely.	
Patient is not tolerating continuous trach mask trials (TMTs) > 24h.	
Previous Conditions	
Patient does not have a condition that precludes the potential for participation in rehabilitation and liberation from mechanical ventilation.	
Other Required Supports	
Patient's current vasopressor requirement is less than 0.5 mcg/kg/min <i>norepinephrine equivalent</i> .	
Patient was not previously requiring long-term (home) invasive mechanical ventilation prior to current admission.	
Patient is not requiring peritoneal dialysis or cardiac mechanical devices (e.g., left ventricular assist device).	
Patient does not require ongoing care that can only be provided by the surgical service at the referring hospital.	
Social Supports & Goals of Care	
Goals of care are clearly established, documented, and appropriate for transfer to a Weaning Program (LSP/PWC).	
Patient and substitute decision maker (SDM) have a clear understanding of the purposes and limitations of the LSP/PWC programs & agree to LSP/PWC consultation.	

Provincial Long-Stay ICU and Weaning Programs Referral Form



Use this form for all Provincial Mechanical Ventilation Weaning Programs including:

- Long Stay Critical Care program (LSP) at Mackenzie Health (MH). LongStay@MackenzieHealth.ca
- Long Stay Critical Care program (LSP) and the Provincial Progressive Weaning Centre of Excellence (PWC) at Michael Garron Hospital (MGH). Prolonged.ventilation@tehn.ca
- MGH will determine which program, LSP or PWC, is best for your patient

All Provincial Mechanical Ventilation Weaning Programs are subject to the Ontario Health directive regarding repatriation of patients when needed.

PATIENT INFORMATION	
First and last name:	
Date of birth:	
Age:	
Gender at birth:	
Gender identity:	
OHIP health card:	
Address:	
Home (Voice) phone:	
Mobile (Text) phone:	
Email address:	
ICU admission date:	

REFERRING CENTRE INFORMATION	
Referring hospital:	
Referring physician:	
Primary application contact:	
Primary contact info:	

SUBSTITUTE DECISION MAKER (SDM)	
First and last name:	
Relationship to patient:	
Home (Voice) phone:	
Mobile (Text) phone:	
Email address:	
Power of attorney paperwork available:	<input type="checkbox"/> Y <input type="checkbox"/> N
Is SDM supportive of application:	<input type="checkbox"/> Y <input type="checkbox"/> N

Provincial Long-Stay ICU and Weaning Programs Referral Form



PATIENT'S SOCIAL SITUATION PRE-ADMISSION:

GOALS OF CARE

Code Status: Full Code DNR except invasive ventilation DNR full medical management Palliative Care

ADMISSION DETAILS

Primary admission diagnoses:

Date of hospital admission:
MM - DD - YYYY

PAST MEDICAL HISTORY and HOSPITAL COURSE:

Please provide patient's past medical history and a synopsis of the patient's course in hospital and pertinent complications (major events, complications, surgeries...)

see dictated chart review / transfer note instead

Provincial Long-Stay ICU and Weaning Programs Referral Form



PAST MEDICAL HISTORY HIGHLIGHTS	
Central Nervous System Disease:	<input type="checkbox"/> Y <input type="checkbox"/> N
Spinal Cord Injury:	<input type="checkbox"/> Y <input type="checkbox"/> N
Hemodialysis dependent:	<input type="checkbox"/> Y <input type="checkbox"/> N
Peritoneal dialysis dependent:	<input type="checkbox"/> Y <input type="checkbox"/> N
Approaching long-term dialysis:	<input type="checkbox"/> Y <input type="checkbox"/> N
If on dialysis or nearing dialysis, which Chronic Kidney Disease Program is the patient known to?	

PRE-HOSPITALIZATION FUNCTION/ INDEPENDENCE	
Activities of Daily Living (e.g., bathing, dressing, grooming, toileting, walking...)	<input type="checkbox"/> Independent <input type="checkbox"/> Needs help <input type="checkbox"/> Dependent <input type="checkbox"/> Cannot do
Instrumental Activities of Daily Living (e.g., shopping, housework, finances...)	<input type="checkbox"/> Independent <input type="checkbox"/> Needs help <input type="checkbox"/> Dependent <input type="checkbox"/> Cannot do

CRITICAL ILLNESS COMPLICATIONS (Please select all that apply)		
<input type="checkbox"/> Slow to wean from IMV	<input type="checkbox"/> Persistently decreased level of consciousness	<input type="checkbox"/> Intolerance of enteral feeds
<input type="checkbox"/> Slow to wean from NIV	<input type="checkbox"/> Persistent agitation	<input type="checkbox"/> Physical deconditioning/ decreased muscle strength
<input type="checkbox"/> Secretions	<input type="checkbox"/> Delirium	<input type="checkbox"/> Clinical polymyoneuropathy
<input type="checkbox"/> Mucous plugging	<input type="checkbox"/> Mood issues	<input type="checkbox"/> EMG-diagnosed polymyoneuropathy
<input type="checkbox"/> Dyssynchrony with ventilator	<input type="checkbox"/> Prolonged vasopressor dependence	<input type="checkbox"/> Diaphragmatic paralysis
<input type="checkbox"/> Respiratory acidosis	<input type="checkbox"/> Malnutrition/ nutritional deficiencies	<input type="checkbox"/> Foot drop
<input type="checkbox"/> Aspiration events/ pneumonia		<input type="checkbox"/> Other (please specify):
<input type="checkbox"/> Ventilator-associated pneumonia		
<input type="checkbox"/> Hypoxemic episodes		

AIRWAY and BREATHING

INVASIVELY VENTILATED PATIENTS	
Date of first intubation:	
How many times has the patient required re-intubation:	
Approximate total number of ventilation days:	
History of difficult intubation:	<input type="checkbox"/> Y <input type="checkbox"/> N
Does the patient have a tracheostomy tube in place:	<input type="checkbox"/> Y <input type="checkbox"/> N
Date of tracheostomy tube insertion:	
Date of last tracheostomy tube change:	
Any tracheostomy or other airway concerns (e.g. tight stoma, subglottic stenosis...):	
Frequency of suctioning:	

Provincial Long-Stay ICU and Weaning Programs Referral Form



MECHANICAL VENTILATION HISTORY	
Ventilator settings / Mode of Ventilation:	
Tolerance of support mode ventilation (e.g., pressure support or other support modes):	<input type="checkbox"/> Tolerates 24 hours per day <input type="checkbox"/> Tolerates during the day only <input type="checkbox"/> Tolerates for limited time (please specify minutes/hours tolerated): <input type="checkbox"/> Does not tolerate any support mode ventilation
Does the patient tolerate spontaneous breathing trials (SBT):	<input type="checkbox"/> Y <input type="checkbox"/> N
If no, why not:	

FOR PATIENTS WITH A TRACHEOSTOMY TUBE	
Have trach mask trials (TMTs) been attempted:	<input type="checkbox"/> Y <input type="checkbox"/> N
Current duration of TMTs in hours:	
Date of LAST trach mask trial (TMT):	
Displayed symptoms/ signs of intolerance? Why was the trach mask trial stopped?	
Was the patient on home mechanical ventilation prior to admission:	<input type="checkbox"/> Y <input type="checkbox"/> N
Was the patient on home non-invasive ventilation (NIV) / BiPAP prior to admission:	<input type="checkbox"/> Y <input type="checkbox"/> N
Was the patient on CPAP prior to admission:	<input type="checkbox"/> Y <input type="checkbox"/> N
In the opinion of the treating clinician, does the patient have the potential to be liberated from mechanical ventilation with time / rehabilitation:	<input type="checkbox"/> Y <input type="checkbox"/> N
In the opinion of the treating physician, what are the barriers to liberation from mechanical ventilation:	

Provincial Long-Stay ICU and Weaning Programs Referral Form



CURRENT REVIEW OF SYSTEMS

HEMODYNAMICS	
Has the patient required vasopressors in the past 72 hours:	<input type="checkbox"/> Y <input type="checkbox"/> N
If yes, names, dosages, pattern (i.e., continuous vs. intermittent):	

RENAL FUNCTION	
Is the patient currently receiving renal replacement therapy:	<input type="checkbox"/> Y <input type="checkbox"/> N
If yes, start date:	
Current type of dialysis:	
Frequency:	
Does the patient require chronic renal replacement therapy:	<input type="checkbox"/> Y <input type="checkbox"/> N

NEUROLOGICAL COMPLICATIONS	
Any major neurological complications during the current hospitalization:	<input type="checkbox"/> Y <input type="checkbox"/> N
If yes, please summarize the clinical deficits and diagnostic imaging report:	

LEVEL OF CONSCIOUSNESS	
Is the patient on sedation at least part of the time:	<input type="checkbox"/> Y <input type="checkbox"/> N
If yes, please indicate type of sedation & dose ranges:	
Level of consciousness (LOC) in the last 72 hours:	
<input type="checkbox"/> Awake and calm <input type="checkbox"/> Awake and agitated <input type="checkbox"/> Drowsy but rousable <input type="checkbox"/> Unresponsive	

DELIRIUM SCREEN	
Does the patient suffer from delirium:	<input type="checkbox"/> Y <input type="checkbox"/> N
Has the patient been in restraints at least part of the time in the past week:	<input type="checkbox"/> Y <input type="checkbox"/> N

Provincial Long-Stay ICU and Weaning Programs Referral Form



PATIENT'S COMMUNICATION ABILITIES			
Is the patient able to follow commands:	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Not consistently
Is the patient able to communicate:	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Language barrier
Is the patient able to use a call bell appropriately:	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Not Consistently
Which of the following communication methods can the patient use appropriately:			
<input type="checkbox"/> Verbal (e.g., trach with speaking valve) <input type="checkbox"/> Mouths words <input type="checkbox"/> Communication devices (e.g., communication board) <input type="checkbox"/> Others, please specify: _____ <input type="checkbox"/> None of the above / unable to communicate.			

PHYSICAL FUNCTION	
Which of the following physical activities has the patient achieved as of this application:	
<input type="checkbox"/> Lying in bed/ passive movements only <input type="checkbox"/> Sitting, exercises in bed <input type="checkbox"/> Sitting over edge of bed, no truncal control <input type="checkbox"/> Sitting over edge of bed, with truncal control <input type="checkbox"/> Mobilization to chair with Hoyer lift/ equipment	<input type="checkbox"/> Mobilization to chair with ≥ 2 person assistance <input type="checkbox"/> Mobilization to chair with 1 person assistance <input type="checkbox"/> Standing with assistance <input type="checkbox"/> Standing without assistance <input type="checkbox"/> Walking with assistance
Is the patient currently able to actively participate with physical therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N
Is the patient mostly motivated to actively participate with physical therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N

DIET	
<input type="checkbox"/> po diet:	
<input type="checkbox"/> enteral feeds:	

SIGN OFF	
Form completed by:	
Designation (i.e., MD, RN, SW...)	
Direct unit phone number:	
Date:	