RESET FORM

Mackenzie Health

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Long Stay Program (LSP) – REFERAL APPLICATION

Please complete the Initial Eligibility Screen form for this patient prior to initiating this Referral Application. Early application is encouraged as we anticipate additional time between receipt of the Initial Eligibility Screen and admission to the unit.

Eligible patients require ongoing critical care supports but are sufficiently stable in services required and are anticipated to have a longer ICU stay before being discharged to the next most appropriate level of care. The LSP Program provides comprehensive care in an appropriate environment, with a focus on optimizing patient recovery and their capacity to reactivate back in the community.

Patients may be **eligible** if they meet the following criteria:

- ☐ Adult patient ≥ 18 years of age currently admitted to a Level 3 ICU within the catchment area.
- ☐ ICU length of stay ≥ 10 days with reasonable evidence based on clinical diagnosis of a much longer need for critical care at the time of application.
- ☐ Requiring invasive or non-invasive ventilation.
- ☐ Not able to tolerate trials of weaning from invasive mechanical ventilation (or weaning from daytime non-invasive ventilation if not invasively ventilated).
- ☐ Hemodynamically stable, with stable or decreasing vasopressor requirements.
- ☐ **Does not have a condition that precludes the potential for participation in rehabilitation and liberation from mechanical ventilation.**
- ☐ Clearly established and documented appropriate goals of care that are consistent with transfer to the Long Stay Unit for rehabilitation and weaning.

Exclusion Criteria

- ☐ Patient is dependent on long-term (home) invasive ventilation prior to current admission.
- ☐ Patient has a known terminal illness (e.g., end-stage cancer, dementia, etc.).
- ☐ Patient's pre-admission Clinical Frailty Score = 8.
- ☐ Patient is on peritoneal dialysis.
- ☐ Patients has advanced chronic kidney disease (CKD) or is approaching the need for long-term dialysis and is known to a CKD program other than Mackenzie Health.
- ☐ Patient is requiring a cardiac mechanical device (e.g., LVAD).
- ☐ Patient requires ongoing care by that surgical service at the referring hospital.

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

PATIENT INFORMATION					
Last name		First name		Gender	
Date of Birth		Age		ICU admission date	

ADMISSION DETAILS		
Primary admission diagnoses:		
Date of hospital admission	Total ICU length of stay, incl. readmissions:	

Please provide a synopsis of course in hospital and pertinent complications [major events, complications, surgeries, etc.] during current hospitalization:

SUBSTITUTE DECISION MAKER (SDM)					
First & Last Name		Relationship to Patient		Telephone	
Is the SDM ***aware & supportive*** of the application to LSP?	◯ Y ◯ N	Have goals of care been discussed?	◯ Y ◯ N		
GOALS OF CARE					
Date of last goals of care discussion		Are goals of care consistent with transfer to LSP for rehabilitation?	◯ Y ◯ N		

Goals of care summary (please include patients'/ SDM's understanding of their current illness and expectations for their trajectory of recovery):

Please also provide the note from the most recent goals of care discussion.

PRE ADMISSION HISTORY

PRE HOSPITALIZATION MEDICAL/ SURGICAL HISTORY [prior to presenting illness]

Central nervous system disease (e.g., stroke, spinal cord injury)	◯ Y	If yes, please specify:	◯ N
Was the patient dialysis-dependent or approaching need for long-term dialysis prior to ICU admission?	◯ Y ◯ N	If yes, which CKD program was the patient known to?	

Please list other pertinent past medical history prior to the current hospitalization:

PRE HOSPITALIZATION FUNCTION/ INDEPENDENCE WITH ACTIVITIES OF DAILY LIVING

Basic activities of daily living (e.g., bathing, dressing, grooming, toileting, walking, etc.):	◯ Independent	◯ Needs help	◯ Dependent	◯ Cannot do
Instrumental activities of daily living (e.g., shopping, housework, finances, etc.)	◯ Independent	◯ Needs help	◯ Dependent	◯ Cannot do

Pre-hospitalization Clinical Frailty Score (CFS) prior to presenting illness: ***Please refer to last page of this application for the CFS scoring.***	

CRITICAL ILLNESS COMPLICATIONS [Please select all that apply.]

- ☐ Slow to wean from IMV
- ☐ Slow to wean from NIV
- ☐ Secretions
- ☐ Mucous plugging
- ☐ Dyssynchrony with ventilator
- ☐ Respiratory acidosis
- ☐ Aspiration events/ aspiration pneumonia
- ☐ Ventilator-associated pneumonia
- ☐ Hypoxic episodes
- ☐ Persistently decreased level of consciousness
- ☐ Persistent agitation
- ☐ Delirium
- ☐ Mood issues
- ☐ Malnutrition/ nutritional deficiencies
- ☐ Intolerance of optimal nutrition (enteral feeds)
- ☐ Prolonged vasoplegia [vasopressor dependence]
- ☐ Physical deconditioning/ decreased muscle strength
- ☐ Clinically diagnosed polymyoneuropathy
- ☐ EMG-diagnosed polymyoneuropathy
- ☐ Diaphragmatic paralysis
- ☐ Foot drop
- ☐ Other [please specify]:

CURRENT REVIEW OF SYSTEMS

NEUROLOGICAL COMPLICATIONS

Were there any major structural neurological complications during the current hospitalization [e.g., ischemic or hemorrhagic stroke, etc.]	◯ Y ◯ 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?	◯ Y ◯ N

- If yes, please indicate type of sedation & dose ranges:

Level of consciousness (LOC) in the in the last 72 hours when **off sedation**: ☐ Unknown/ Never off sedation

Best LOC	◯ Awake, alert, calm	◯ Awake and agitated	◯ Drowsy but rousable	◯ Unresponsive
Worst LOC	◯ Awake, alert, calm	◯ Awake and agitated	◯ Drowsy but rousable	◯ Unresponsive

DELIRIUM SCREEN

Type of screening tool: ◯ CAM-ICU ◯ ICDSC ◯ Other [please specify]

Best score:	Worst score:	Has the patient been in restraints at least part of the time in the past week	◯ Y ◯ N

PATIENT COMMUNICATION ABILITIES

Is the patient able to follow commands?	◯ Y ◯ N ◯ Inconsistently	Is the patient able to communicate?	◯ Y ◯ N ◯ Limited due to language barrier

Which of the following communication methods can the patient use appropriately [**select all that apply**]:

- ☐ Verbal [e.g., tracheostomy with speaking valve]
- ☐ None of the above [i.e., unable to communicate]
- ☐ Mouths words
- ☐ Others, please specify:
- ☐ Low technology alternative communication devices (e.g., communication board)

Is the patient able to use a call bell appropriately?	◯ Y ◯ N ◯ Not Consistently

AIRWAY

INVASIVELY VENTILATED PATIENTS

Date of first intubation:	_____	How many times has the patient required re-intubation?	
Total number of invasive ventilation days:	_____	History of difficult intubation? ◯ Y Please specify:	◯ N

Does the patient have a tracheostomy tube in place? ◯ Y → Date of trach insertion: ◯ N

MECHANICAL VENTILATION/WEANING HISTORY

FOR PATIENTS WITH AN OROTRACHEAL TUBE

Ventilator settings [if variable, may provide mode plus setting ranges]:		Date of first spontaneous breathing trial (SBT):	

Tolerance of ***support mode*** ventilation (e.g., pressure support or other support modes):

- ◯ Tolerates 24 hours per day
- ◯ Tolerates during the day only
- ◯ Tolerates for limited time [please specify minutes/hours tolerated:
- ◯ Does not tolerate *any* support mode ventilation

Displayed symptoms/ signs of intolerance?

FOR PATIENTS WITH A TRACHEOSTOMY TUBE

Have trach mask trials (TMTs) been attempted?	◯ Y ◯ N	Current ventilator settings when the patient is ventilated:	
If yes, trach mask trial initiation date: _____		Current number of minutes of consecutive TMTs tolerated?	

Displayed symptoms/ signs of intolerance?

In the opinion of the treating clinician, does the patient have the potential to be liberated from mechanical ventilation with further time/ rehabilitation?	◯ Y ◯ N

In the opinion of the treating physician, what are the barriers to liberation from mechanical ventilation?

CURRENT RESPIRATORY INTERVENTIONS

☐ Cough assist	☐ Chest percussions	☐ Manual assisted cough	☐ Tracheal suctioning	☐ Other [please specify]:

HEMODYNAMICS

Has the patient required vasopressors in 72 hours?	◯ Y ◯ N

If yes, please indicate names & dosages and pattern (i.e., continuous vs. intermittent):

RENAL FUNCTION

Is the patient currently receiving renal replacement therapy?		◯ Y ◯ N
If yes, Start date: ____	Type of dialysis:	Frequency:
Is there an expectation that the patient will require chronic dialysis?		◯ Y ◯ N

PHYSICAL FUNCTION

Which of the following physical activities has the patient achieved as of this application:

- ☐ Lying in bed/ passive movements only
- ☐ Sitting, exercises in bed
- ☐ Sitting over edge of bed, no truncal control
- ☐ Sitting over edge of bed, with truncal control
- ☐ Mobilization to chair with hoyer lift/ other similar equipment
- ☐ Mobilization to chair with ≥ 2-person assistance
- ☐ Mobilization to chair with 1 person assistance
- ☐ Standing with assistance
- ☐ Standing without assistance
- ☐ Walking with assistance

Frequency of physical therapy:	sessions ◯ per day ◯ per week	Is the patient currently able to actively participate with physical therapy?	◯ Y ◯ N

- If not, what are the obstacles?

WOUND/SKIN

Does the patient have any current wounds? ◯ Y ◯ N

- If yes, please describe the sites and stages of any wounds/ ulcers:

NUTRITION

Has the patient been receiving nutrition in the past 72 hours? ◯ No feeds due to intolerance ◯ No feeds due to other reason [please specify] ◯ Yes, enteral feeds ◯ Yes, parenteral feeds

INFECTIOUS DISEASES

Does the patient currently have any active infections? ◯ Y ◯ N

If yes, please provide details:

LINES & TUBES

Please indicate which of the following lines or tubes the patient has in place:

- ☐ Nasogastric (NG), orogastric (OG), or nasojejunal (NJ) tube
- ☐ J-tube or PEG tube
- ☐ Central venous catheter
- ☐ PICC line
- ☐ Arterial line
- ☐ Other lines & tubes [please list & describe date of insertion & indication]:

Thank you for completing this form. Please send the completed form to both email addresses below. We will be in touch with you shortly.

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