Michael Garron Hospital (MGH) Long-Term Ventilation Referral Form

-Use this form to apply to **the Long-Term Ventilation (LTV) program at MGH**
-LTV at MGH is in our Complex Continuing Care (CCC) Unit for patients needing permanent hospitalization for chronic invasive mechanical ventilation
-Send the completed referral form to prolonged.ventilation@tehn.ca

-Note: please use our **MGH Ventilation Weaning Programs referral form** for patients that are slow to wean off mechanical ventilation or that might still wean off mechanical ventilation

Michael Garron Hospital
Ventilation and Weaning Programs
825 Coxwell Ave E
Toronto, ON, M4C 3E7
416 671 5716 (phone)
416 469 6377 (fax)
prolonged.ventilation@tehn.ca

PATIENT INFORMATION	
First and last name:	
Date of birth:	
OHIP health card:	
Address:	
Home phone:	
Mobile phone:	
Email address:	

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

SUBSTITUTE DECISION MAKER (SDM)	
First and last name:	
Relationship to the patient:	
Home phone:	
Mobile phone:	
Email address:	
Power of attorney paperwork available?	☐ Y ☐ N

POWER of ATTORNEY for FINANCES (if different from above)	
First and last name:	
Home phone:	
Mobile phone:	
Email address:	
List of any financial resources available to the patient (e.g. pensions, savings, insurance, ODSP….):	

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

GOALS OF CARE

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

PROGNOSIS

☐ Improve
☐ Remain stable
☐ Deteriorate

☐ Prognosis discussed with patient

☐ Prognosis discussed with SDM

Comments:

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

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

PAST SURGICAL HISTORY

Please provide patient's past SURGICAL history (if different from above)
☐ see dictated chart review / transfer note instead

PAST PSYCHIATRIC HISTORY

Please provide patient's past PSYCHIATRIC history (if different from above)
☐ see dictated chart review / transfer note instead

MEDICATIONS

Allergies:

List medications or attach MAR (preferred)

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

AIRWAY and BREATHING

TRACHEOSTOMY	
Type and size of tracheostomy tube?	
Date of tracheostomy tube insertion:	
Date of last tracheostomy tube change:	
Describe any tracheostomy or airway concerns (e.g. tight stoma, subglottic stenosis, granulomas…):	
Frequency of suctioning?	
Is the patient able to suction themselves?	☐ Y ☐ N

MECHANICAL VENTILATION HISTORY		
Ventilator settings:		
FiO2:		
Patient's current weight:		kg
Mode of Ventilation:		
Tidal Volume:		ml
Pressure Support:		cmH2O
Pressure control:		cmH2O
PEEP:		cmH2O
Does the patient come off the ventilator during the day?		☐ Y ☐ N
If yes, for how many hours:		
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; minutes/hours tolerated: ____	☐ Does not tolerate any support mode ventilation
Comments:		

DIAPHRAGM PACER	
Diaphragm pacer?	☐ Y ☐ N
If yes, does patient have bilateral diaphragm pacing?	☐ Y ☐ N
Other details:	

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

COGNITION, MOOD, BEHAVIOUR		
Is the patient alert?	☐ Y	☐ N
Is the patient interactive?	☐ Y	☐ N
Is the patient's judgement intact?	☐ Y	☐ N
Can the patient make healthcare decisions?	☐ Y	☐ N
Can the patient follow commands?	☐ Y	☐ N
Is the patient cooperative?	☐ Y	☐ N
Does the patient participate in their daily care?	☐ Y	☐ N
Does the patient suffer from delirium?	☐ Y	☐ N
Does the patient require restraints?	☐ Y	☐ N
Does the patient suffer from anxiety?	☐ Y	☐ N
Does the patient suffer from depression?	☐ Y	☐ N
Does the patient have behavior issues:	☐ Y	☐ N
Please provide details regarding behavior issues:		

NURSING		
Can the patient turn independently?	☐ Y	☐ N
Does the patient transfer to chair daily?	☐ Y	☐ N
How many caregivers are needed for transfer?		
Does the patient have any pressure injuries (bedsores)?	☐ Y	☐ N
If yes, describe location, staging, and current wound care interventions:		
Does the patient have any venous access devices / lines? (e.g. PICC line…)		
When was it inserted?		
Does the patient have any other lines / drains / tubes? (e.g. foley, ostomy….)		
If yes, when was it inserted or last changed?		
Please attach patient's daily care plan:		

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

COMMUNICATION ABILITIES			
Patient's primary language			
Is the patient able to communicate?	☐ Y	☐ N	☐ Language barrier
Is the patient able to use a call bell appropriately?	☐ Y	☐ N	☐ Not Consistently

Which of the following communication methods can the patient use appropriately?

☐ Verbal (e.g., trach with speaking valve)

☐ Mouth words

☐ Communication Device

☐ Other: _____

☐ None of the above / unable to communicate.

SWALLOWING AND DIET		
Is the patient able to swallow?	☐ Y	☐ N
Feeds by mouth?	☐ Y	☐ N
Does the patient require assistance with feeding?	☐ Y	☐ N
G tube?	☐ Y	☐ N
J tube?	☐ Y	☐ N
Date of insertion or last change of feeding tube?		
Describe any issues or concerns about the patient's feeding tube:		
Type of enteral feeds / current regimen:		
Other dietary concerns:		

OCCUPATIONAL THERAPY		
Can patient use a telephone?	☐ Y	☐ N
Can patient use a tablet?	☐ Y	☐ N
Can patient use a TV/stereo?	☐ Y	☐ N
Can patient use a computer?	☐ Y	☐ N
Does patient have their own device?	☐ Y	☐ N
Other:		

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

MOBILITY/EQUIPMENT OWNED BY PATIENT		
Walker	☐ Y	☐ N
Wheelchair	☐ Y	☐ N
Specialty mattress	☐ Y	☐ N
Hospital bed	☐ Y	☐ N
Mechanical lift	☐ Y	☐ N
Commode	☐ Y	☐ N
Cough Assist insufflator/exsufflator	☐ Y	☐ N
Portable suction unit	☐ Y	☐ N
Ventilator/BiPAP/CPAP	☐ Y	☐ N
Other:		

SOCIAL SITUATION
Please outline the patient's current family situation (ie: marital status, siblings, offspring)
Describe in what way the patient's family and friends are involved in the patient's care:
What are the care issues raised by the patient/family in the past 2 months?

ADDITIONAL QUESTIONS
What are the most significant care issues for this patient since their admission?

SIGNATURE	
By signing this application, I confirm that the information in this application is complete.	
Physician Signature:	Date:
Physician name (print):	Billing #:
Tel:	
Fax:	
Email:	

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

prolonged.ventilation@tehn.ca

Contact Information

Michael Garron Hospital Ventilation and Weaning Programs 825 Coxwell Ave E Toronto, ON, M4C 3E7 416 671 5716 (phone) 416 469 6377 (fax)	**Long-Term Mechanical Ventilation** Karen Kerry, Manager, J5 Phone 416 469 6580 x 3594 karen.kerry@tehn.ca
Director MGH Ventilation and Weaning Programs – Marcus J. Kargel MD FRCPC FCCP	
Prolonged.ventilation@tehn.ca	