MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

CCC Long-Term 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 prolonged.ventilation@tehn.ca or fax # 416-469-7717

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:_____

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

Date of recent Trach Tube Change:_____

_____

Frequency of Trach Changes:_____

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

Stoma Condition:_____

Granulomas: _____
Stenosis:_____
Stoma infections:_____

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.