Prolonged-ventilation Weaning Centre (PWC) & Provincial Centre for Weaning Excellence
Phone: 416-469-6580 ext. 6841
Fax: 416-469-7717
prolonged.ventilation@tehn.ca
TEGH facility number: 1302

*PWC REFERRAL REQUEST FORM

PATIENT INFORMATION									
Last name		Middle name		First name					
Date of birth	/ / (dd/mmm/yy)	Gender	☐F ☐M	**OHIP (+vc)**					
Address		Phone		( ) -					
Marital status	☐ Married	☐ Common law	☐ Divorced/separated	☐ Widowed	☐ Single				
Premorbid location	☐ Home	☐ Assisted-living	☐ Nursing home	☐ Rehabilitation	☐ Unknown				
Premorbid status	☐ Fully active	☐ Restricted in strenuous activity	☐ Ambulatory, capable of self-care but not work						
	☐ Bedridden 50% or more of the time, limited self-care								
	☐ Totally bedridden and disabled, no self-care								

REFERRING HOSPITAL CONTACT INFORMATION			
Hospital Name		Address	
Phone	( ) - Ext		
Fax (ICU)	( ) -	**Hospital facility number**	
Physician's Name		**Physician's OHIP billing number**	

OTN Telemedicine Site Location (for PWCTeleconsultation)

APPLICATION CONTACT PERSON					
Last name		First name		Position	
Phone	( ) - Ext				
Email					

SUBSTITUTE DECISION MAKER (SDM) or Power of Attorney (POA)					
Last name		First name		Relationship	
SDM/POA agrees to be contacted by Michael Garron Hospital's clinical team		☐YES ☐No		Phone	( ) -

ADMISSION DETAILS	
Date of hospital admission	[/ /] (dd/mmm/yy)
Date of ICU admission	[/ /] (dd/mmm/yy)
Primary Diagnosis	

Secondary Diagnoses _____

CO-MORBIDITIES

☐	Right ventricular failure (cor pulmonale)	☐	Interstitial lung disease/pulmonary fibrosis
☐	Coronary artery disease	☐	Prior lung resection
☐	Congestive heart failure	☐	Pulmonary vascular disease
☐	Aortic stenosis	☐	Respiratory neoplasm
☐	Atrial arrhythmias	☐	Prior lung resection
☐	Peripheral vascular disease	☐	COPD
☐	Hypertension	☐	Dementia
☐	Kyphoscoliosis/chest wall restriction	☐	CVA: type _____
☐	Liver disease	☐	Moderate to severe renal disease

☐ Other (please describe)

REASONS FOR FAILURE TO WEAN/PROLONGED VENTILATOR DEPENDENCE

Did the patient experience surgery or surgical complications that resulted in PMV? ☐ Yes ☐ No

If yes, please describe: _____

Please indicate which of the following have contributed to PMV:

☐ CPR	☐ AMI/unstable angina	☐ CHF	☐ COPD exacerbation (no pneumonia)
☐ VAP	☐ Aspiration pneumonitis	☐ ARDS	☐ COPD exacerbation (with pneumonia)
☐ PE	☐ Status asthmaticus	☐ Pneumothorax	☐ Community acquired pneumonia (no COPD)
☐ CVA/ICH	☐ Mucus plug/atelectasis	☐ Kyphoscoliosis	☐ Obesity-hypoventilation syndrome
☐ NMD	☐ Neurologic infection	☐ Guillian Barre	☐ Sepsis
☐ DKA	☐ Head trauma	☐ Chest trauma	☐ Metabolic coma
☐ Malnutrition	☐ Acute renal failure	☐ Other	

Other reasons for Failure to Wean/Prolonged Ventilator Dependence _____

MECHANICAL VENTILATION and AIRWAY

Date of onset of mechanical ventilation: [/ /] (dd/mmm/yy)

Has the patient required mechanical ventilation prior to this admission? ☐ Yes ☐ No ☐ Unknown

Date of tracheostomy insertion: [/ /] (dd/mmm/yy)

Type of tracheostomy _____ Size [ ]

Any complications associated with the tracheostomy? _____

Has a swallowing study been done? ☐ Yes ☐ No Date most recent assessment: [/ /]

Type of assessment: _____

Results: _____

CURRENT VENTILATOR SETTINGS

Ventilator mode	[ ] ☐ Volume ☐ Pressure		
Mandatory respiratory rate	[ ]	Spontaneous respiratory rate	[ ]
Set tidal volume	[ ] mL	Spontaneous tidal volume	[ ] mL
Set inspiratory pressure	[ ] cm H_2O	Minute ventilation	[ ] L/min
Pressure support	[ ] cm H_2O	PEEP	[ ] cm H_2O
Peak inspiratory pressure	[ ] cm H_2O	Mean inspiratory pressure	[ ] cm H_2O
FiO_2	[ ]	PAV % (if applicable)	[ ] %

MOST RECENT BLOOD GAS

☐ ARTERIAL ☐ VENOUS

Date taken [/ /] FiO_2 [ ]

Recorded on: ☐ Trache mask ☐ CPAP/PSV ☐ AC/SIMV/PCV

pH [ ] $PaCO_2$ [ ] mmHg PaO_2 [ ]mmHg

WEANING HISTORY

Number of failed extubations [ ] Current weaning method:

Has the patient tolerated a spontaneous breathing trial? ☐ Yes ☐ No

If yes, what was used? (tick all that apply Trach mask ☐ PAV+ ☐ PSV ☐ CPAP ☐

How long was the longest TM/PAV trial? [ ] Date of longest trial [/ /]

Factors identified as contributing to weaning failure

☐ Anxiety ☐ Nutritional status ☐ Muscle weakness/paralysis

☐ Advancing respiratory disease

☐ Other _____

Smoking history	☐ Never smoked	☐ smoker	☐ active	☐ former	☐ unknown

AIRWAY STATUS

Cuff deflation: ☐ No testing ☐ Does not tolerate ☐ Tolerates > 1 hr ☐ Speaking valve > 1 hr

MOST RECENT CLINICAL LABORATORY TEST VALUES

WBC (x10^9/L)	[ ] x10^9/L	Platelets (x10^9/L)	[ ] x10^9/L
Hemoglobin (g/L)	[ ] g/L	Hematocrit (%)	[ ] %
Sodium (mmol/L)	[ ] mmol/L	Potassium (mmol/L)	[ ] mmol/L
Glucose (mmol/L)	[ ] mmol/L	Albumin (g/L)	[ ] g/L
Serum creatinine (umol/L)	[ ] umol/L	Urea (mmol/L)	[ ] mmol/L
Total bilirubin (umol/L)	[ ] umol/L	INR	[ ]

NOTE if other measurement units are used in your institution please identify above.

Cultures (Attach reports)

☐Sputum	☐Urine	☐Stool	☐Blood	☐Other(Specify)

ANTIBIOTIC RESISTANT ORGANISMS				
☐ MRSA	☐ C diff	☐ VRE	☐ ESBL	☐ Other (describe)

PLEASE ATTACH RELEVANT LAB RESULTS INCLUDING MICROBIOLOGY REPORTS and MOST RECENT CHEST X-RAY/ECHOCARDIOGRAM REPORTS

COMMUNICATION

Is the patient able to communicate?	☐ Yes	☐ No
Is the patient able to follow commands/direct care	☐ Yes	☐ No

Communication Method

☐ Verbal (tolerates cuff deflation)	☐ Mouths words	☐ Writes	☐ Speaking Valve
☐ Communication board	☐ Other(Specify)		

Cough Augmentation

☐ Cough Assist	☐ Chest PT	☐ Manually assisted cough and lung volume recruitment using manual resuscitation bag

Frequency of suction in ICU:

Other interventions

LINES/TUBES and DATE OF INSERTION

☐ PICC ☐ Foley

NUTRITION

Present weight	[ ] kg	Ideal weight	[ ] kg

☐ PEG ☐ NG ☐ ORAL ☐ TPN

Please describe feeding regime: _____

Does the patient have decubitus ulcers?	☐ Yes	Location	Stage	☐ No

MUSCULOSKELETAL/ACTIVITY LEVEL

Does the patient require special equipment for transfer?	☐ Yes (describe)	☐ No
Does the patient require special equipment for sitting?	☐ Yes (describe)	☐ No

Has the patient achieved any of the following?

Unassisted dangling	☐ Yes	☐ No
Assisted weight bearing	☐ Yes	☐ No
Unassisted weight bearing	☐ Yes	☐ No
Mobilization to chair with maximal (≥ 2 person) assistance	☐ Yes	☐ No
Mobilization to chair with minimal (1 person) assistance	☐ Yes	☐ No
Walking with assistance	☐ Yes	☐ No

Mobility Scale at Time of Application – Highest Mobility To Date

☐ Nothing (lying in bed) Passive roll	☐ Sitting, exercises in bed

☐ Passively moves to chair, no standing	☐ Sitting over edge of bed
☐ Standing, with or without assist	☐ Transferring to chair
☐ Marching on spot	☐ Walking with assistance – 5 metres min. 2 persons assist
☐ Walking 1 person assist	
☐ Walking independently with gait aid	☐ Walking 5 metres with no aid

BEHAVIOURAL/COGNITIVE ISSUES

Can the patient operate a call bell appropriately and reliably? ☐ Yes ☐ No

Has the patient required restraints in the past 7 days) ☐ Yes ☐ No

If yes, describe why _____

Has the patient been seen by psychiatry during the current ICU admission? ☐ Yes ☐ No

Is the patient currently receiving treatment for any of the following?

Depression ☐ Yes ☐ No Anxiety ☐ Yes ☐ No Other ☐ Yes ☐ No

If yes, please describe: _____

Cognitive function ☐ Normal ☐ Mildly impaired ☐ Moderately impaired ☐ Profoundly impaired

PLEASE ATTACH RELEVENT REPORTS FROM PSYCHIATRY

SOCIAL SITUATION

Please describe the patient's social situation and involvement of family members and significant others

_____

Please attach documented goals of care conversations

Please indicate if an application has been submitted to a Long Term Ventilation Program ☐ Yes ☐ No

Has patient/family information about the PWC been provided (if applicable)? ☐ Yes ☐ No

OTHER PERTINENT INFORMATION

Please provide any other information you believe pertinent to this referral for consultation

_____

Thank you. We will contact you within 2 working days