VENTILATOR DEPENDENT CLIENT APPLICATION

Parkwood Institute - Complex Care Program

FAX completed form to (519) 685-4804 -------

Please ensure that you have included all pertinent patient information.

In addition to submitting this completed application, provide additional information pertaining to: ☐ Wound Care Plan ☐ History ☐ Other:

Last Name:	**First Name**	**Date of Birth: (y/m/d)**	**Age:**
SEX: ☐ Male ☐ Female	**MARITAL STATUS:**	**OHC:** ☐☐☐☐■☐☐☐■☐☐☐■ Version☐☐	
Client's Current Location: ☐ Home	**Street Address:**	**City:**	**Postal:**
☐ Facility:			
Has the patient identified a POA: Yes ☐ No ☐			
Personal Care: ***(Contact Info & Relationship)***			
Financial: ***(Contact Info & Relationship)***			
Medically Stable: Yes ☐ No ☐	Prognosis discussed with: Client ☐ Family ☐		

Contacts: Discipline	**Name**	**Phone #**
Primary Contact:		
Physician:		
Nursing:		
Respiratory Therapist:		
Physio:		
Occupational Therapist:		
Social Worker:		
Dietitian:		
Therapeutic Recreation Specialist		
Pharmacist:		
Psychologist:		
Speech Language Pathologist:		

Admitting Diagnosis: **Date of Admission:**
Course of current illness during hospitalization: **(include previous medical history as attachment)**
What attempts have been made to wean client from ventilator: **(may be attached)**
Why is the client unable to wean from the ventilator:
Is there are Respirologist who has been following this patient to date:
MEDICATIONS: ***Please attach medication list with name, dosage and frequency of administration.***

Is there any history of substance abuse?

TRACHEOSTOMY/SUCTIONING

Tracheostomy type: Size: Insertion Date: Date Last Changed:

Cuff Routine: ☐ Inflated (Volume_____) ☐ Deflated ☐Cuffless

☐ Cork/Valve Routine - Details: (ie: valve or cork) _____ # of hours _____hrs/24hrs)

Has client had any training/practice with cuff manipulation/trach care, etc? Yes ☐ No ☐

Details:

Suctioning: Frequency of suctioning: _____ Can client suction self? Yes ☐ No ☐

Details:

Does client have a problem with aspiration? Yes ☐ No ☐ - Details:

History of chest infections while in hospital:

NON-INVASIVE VENTILATION

When was ventilation initiated: Does patient have own unit?

☐ BiLevel ☐ CPAP – Setting: _____ Is oxygen t'd into system? Yes ☐ No ☐

Details:

INVASIVE MECHANICAL VENTILATION

When was ventilation initiated?

Daily Routine: How long is client ventilated (hrs/24hrs)?

During time off (if applicable), what adjuncts are applied? (ie: humidity, etc):

Lung volume recruitment/airway secretion management techniques:

☐ B-stacking ☐ Assisted cough ☐ MI-E Frequency:

How long can spontaneous ventilation be maintained?

How often is client "bagged"?	Is supplemental 0_2 used for this?

Can client "bag" her/himself?

Current Ventilator Model:

Mode:	$Fi0_2$:	V.T.:	PEEP:	R.R.:	Humidification:
Blood Gases:	On/off vent?	Date:			

☐ Cap	☐Art	FiO_2		
PO2	PCO2	PH	H2CO3	BE

CURRENT LAB RESULTS: (If not available on Cerner)		**Date:**		
Hgb	K	BUN	Ca	WBC
Na	CR	Alb	HcT	Cl
Glob	PT	PTT		

DETAILS OF FAMILY/CAREGIVER SUPPORT (for ventilator and tracheostomy management only):	
Does client have caregiver trained to support suctioning /ventilator care needs: ☐Yes ☐ No	
If so, is trained caregiver willing to support therapeutic activities: on unit ☐ off unit ☐	
Name of Caregiver & relationship to client:	**Skills Achieved:**

Are there any family members/caregivers who wish to gain these skills?
Can this be achieved or initiated prior to Complex Care admission?

CARDIOVASCULAR ASSESMENT:
Hemodynamically stable over past 2 weeks: Yes☐ No☐
Cardiac Monitor Yes☐ No☐
Current vital sign routine: daily ☐ weekly ☐

COMMUNICATION: ***(Please attach a SLP Assessment if completed)***
Is client able to communicate with care team? Yes ☐ No ☐ Does the client: Speak ☐ Mouth words ☐
Does the client use augmentative communication devices ☐ - Please describe:
What is the language normally spoken and understood by client?
Does the client use the standard call bell appropriately? - Yes ☐ No ☐
Please describe any assistive devices that have been used to support this client -

COGNITIVE:		
Is the client alert? Yes ☐ No ☐	Oriented to: Time ☐ Person ☐ Place ☐	
Memory: Intact ☐ Impaired ☐	**Judgement:** Intact ☐ Impaired ☐	**Insight:** Intact ☐ Impaired ☐
Use of restraints: Yes☐ No☐		

BEHAVIOUR: ***(If a Behaviour Plan is in place, please ATTACH).***
Is the client anxious? Most of the time ☐ occasionally ☐ sometimes ☐ not at all ☐
Is the patient cooperative? Most of the time ☐ occasionally ☐ sometimes ☐ not at all ☐
Has the client taken an active role in his/her care (actively participates and/or provides direction?) Most of the time ☐ occasionally ☐ sometimes ☐ not at all ☐

NUTRITION:
Ability to eat: Independent ☐ Dependent☐ Assist ☐ Difficulty swallowing ☐ Difficulty chewing ☐
Has an MBS been completed: Yes ☐ No ☐ ***If YES, please ATTACH RESULTS.***
Feeding Tube: NG☐ G☐ GJ☐ PEG☐ Date Inserted: _____ By whom: _____
Type of Feeding/Rate:

Pre-admission wt: _____kg Present Wt: _____kg Ideal Wt: _____kg Height _____cm

Complex Care Program does not provide care to patients who require Total Parenteral Nutrition (TPN).

SKIN CONDITION:

Is client at risk to develop skin breakdown? Yes☐ No☐ Is there a history of skin breakdown in the past? Yes ☐ No ☐

If yes, please answer the following: Area(s) involved:

Is there any skin breakdown at present? Yes☐ No☐ Date of Onset:

Briefly describe the areas of skin breakdown and current treatment plan:

Does the client have a special mattress? Yes ☐ No ☐ What type?

PLEASE ATTACH DESCRIPTION OF ANY WOUNDS & WOUND CARE ROUTINE (if applicable).

ELIMINATION:

Urinary: Continent☐ Incontinent☐
Management: Diapers☐ Condom catheter☐ Indwelling Catheter☐ Type:_____ Last Change: _____
Intermittent catheterization: ☐ Frequency: _____

Bowel: Continent☐ Incontinent☐

Bowel Routine:

DAILY HYGIENE MANAGEMENT:

	Independent	Assistance Needed	Supervision	Dependent
Shaving	☐	☐	☐	☐
Oral Care	☐	☐	☐	☐
Bathing/Washing	☐	☐	☐	☐

MUSCULOSKELETAL STATUS:

Does client have active ROM?	**Functional**	**Non-Functional**
Of neck	☐	☐
Of Arms	☐	☐
Of Legs	☐	☐

Does the client have passive ROM limitations? Yes ☐ No ☐

Please describe any: Contractures/Pain/Oedema:

Muscle tone: ☐ Functional ☐ Increased ☐ Decreased

Orthopaedic Problems:

Interventions for above:

MOBILITY & TRANSFERS:

Is the client ambulatory? Yes ☐ No ☐ Distance: Gait aid:

Mobility Aids: Wheelchair – manual ☐ power ☐ Client able to self-propel: Yes ☐ No ☐ Walker: Type -

Has the mobility aids been prescribed ☐ ordered ☐

Can the ventilator be supported on the mobility device: Yes ☐ No ☐

Sitting tolerance:

Is there hypotension with transfers? Intervention Required:

Mode of transfer: Mechanical lift☐ Manual transfer☐ Assist x:

Other:

Specify:

Can client shift his/her own weight in: Chair - Yes☐ No ☐ Bed – Yes ☐ No ☐ Assistance required Yes ☐ No ☐

EQUIPMENT:		
Please list all equipment current in use by clients to support ADL's, e.g.ventilators, cables, battery chargers, suction equipment, environmental controls).		
	Owned☐	Borrowed☐ From where:
	Owned☐	Borrowed☐ From where:
	Owned☐	Borrowed☐ From where:
	Owned☐	Borrowed☐ From where:
	Owned☐	Borrowed☐ From where:
	Owned☐	Borrowed☐ From where:
	Owned☐	Borrowed☐ From where:
	Owned☐	Borrowed☐ From where:

ACCESS TO ENVIRONMENT:	
Can client activate call bell? Yes ☐ No ☐ If yes, what type?	Excessive use: Yes ☐ No ☐
Telephone: Independent ☐ Assistance ☐ Dependent ☐	**TV/Stereo:** Independent ☐ Assistance ☐ Dependent ☐
Computer: Independent ☐ Assistance ☐ Dependent ☐	**Other:**

SOCIAL SITUATION:
Please outline the client's present family situation & current family stressors (ie. Marital status, siblings, offspring, financial, child care).
Indicate involvement of family and friends since client became ventilated (ie. Visiting, outside activities, assistance in care routines where permitted.
Have the client or family had particular difficulty adjusting to client's condition? Yes ☐ No ☐ , If yes, please describe:
Identify pt status prior to chronic ventilation (e.g., hobbies & interests, activity, personality, etc)
How does patient pass their time while in ICU:

Social Work/Psychology/Psychiatric Intervention:
CLIENT GOALS:
Has the client been able to identify personal goals for care? Yes ☐ No ☐
What are the client's short term goals?
What are the client's long term goals?
Please provide a detailed description of the patient's Resuscitation Status, discussions involved, and presence of patient with these discussions.
Has the client been informed that Parkwood Complex Care is a Residential setting for Ventilator Dependent individuals? Yes☐ No☐
Signature of person completing form: **Title:**

Complex Continuing Care Program
Parkwood Institute

Complex Continuing Care (CCC) provides continuing, medically complex and specialized services to both young and old, sometimes over extended periods of time. CCC is provided in hospitals for people who have long-term illnesses or disabilities typically requiring skilled, technology-based care not available at home or in long-term care facilities. CCC provides patients with room, board and other basic necessities in addition to medical care.

All patients in Complex Continuing Care are charged a "Complex Continuing Care Co-payment". This co-payment is the patient's contribution toward their accommodations and meals. The CCC co-payment rate is set by the Ministry of Health and Long Term Care. For the most current rate and answers to frequently asked questions visit http://www.health.gov.on.ca/en/public/publications/chronic/chronic.aspx**.** This rate may be reduced in some cases, based on an individual's income and number of dependents. A representative from the Finance Office will meet with you or your family following your admission, to determine if you qualify for a rate reduction.

I consent to this application to Complex Continuing Care at Parkwood Institute on behalf of myself/family member. I understand that the CCC co-payment will be applied and that this rate will be determined in conjunction with the Finance Office following my admission to CCC.

_____ _____

Signature of Patient Date

_____ _____

Signature of Substitute Decision Maker Date

_____ _____

Witness Date