Ontario Health atHome

Fax completed form to **519-742-0635**

Patient Name:

HCN:

Complex Medical / Long Term Vent Referral

Please Include Documentation to Support the Application	**Program:**
☐ Demographic Information ☐ Letter of Understanding (Consent and Information Letter) ☐ Relevant Progress Notes from last 7 days (May include OT, PT, SLP, RD, Nursing) ☐ Comprehensive history & physical ☐ Medication Administration Record (to be sent at Bed Offer)	☐ Complex Medical Management (WRHN @Chicopee or SJHCG) ☐ Chronic Assisted Ventilator (WRHN @Chicopee) ***Please ensure page 5 criteria checklist is completed**

Patient Current Location (Hospital, Floor, Room /Bed) :

Phone Number for Nursing Unit :

Phone Number for Bed offer :

MEDICAL INFORMATION

Medically Stable: ☐ Y ☐ N (Medical issues have resolved/stabilized. There is no plan to change active treatment based on an actively changing condition.)

Primary Diagnosis:

Past Medical History: (can attach notes)

History of Present Illness / Surgery: (can attach notes)

Active Medical Issues:

Allergies:

Follow-Up Appointments / Upcoming Appointments / Imaging:

CLINICAL INFORMATION

Smoking Status: Smoker: ☐ Y ☐ N

Speech/Communication : ☐ Aphasia/Dysarthria ☐ Difficulty Communicating ☐ Unable to Communicate ☐ Adequate Language:

Communication Device use?

Hearing Impaired : ☐ Y ☐ N **Vision Impaired :** ☐ Y ☐ N

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Patient Name:

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Nutrition: ☐ Standard Diet ☐ Diet type: ☐ Enteral feeds: **complete details on page 3**

Texture: Fluid Consistency: ☐ Swallowing concerns:

Dentures:

Bladder: ☐ Routine Toileting ☐ Occasionally Incontinent ☐ Incontinent

☐ Full Control ☐ Foley Catheter Change Due:

Bowel: ☐ Routine Toileting ☐ Occasionally Incontinent ☐ Incontinent

☐ Full Control Date of last BM :

Ostomy: ☐ Y ☐ N Specify products:

☐ Independent with Care ☐ Assistance with care ☐ Total care

IV Therapy: ☐ Y ☐ N

IV Antibiotics: ☐ Y ☐ N Frequency / Duration:

PICC Line: ☐ Y ☐ N Length: Insertion date:

Dialysis: ☐ Y ☐ N Frequency / Duration:

Radiation: ☐ Y ☐ N Frequency / Duration:

Chemotherapy: ☐ Y ☐ N Frequency / Duration:

Cognition

WNL = Within Normal Limits **I = Impaired**

	WNL	I	Comments
Cognitive Function			
MoCA Score			
Ability to Learn / Retain Information			

Responsive Behaviours : ☐ Y ☐ N ☐ Aggression (Verbal / Physical) ☐ Exit seeking / Wandering ☐ Resisting care ☐ Need for constant

ADL Function

Ind = Independent **SU = Setup Only** **S = Supervision** **A = Assistance**

	Ind	SU	S	A	Comments (Min/Mod/Max A/x1/x2 Baseline)
Feeding					
Grooming					
Dressing					
Toileting					
Bathing					

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Goals of Care Discussed with patient/family (please include any notes):

_____

Code Status : _____

Palliative Care Team Involved: ☐ Y ☐ N

Isolation (must have recent swabs for MRSA/VRE/ESBL/CPE): _____

Diet / Tube Feed Formula and Settings: _____

_____

Bowel / Bladder routines: _____

Current weight: _____

Skin and Wound issues: _____

_____

Equipment Needs (i.e. mattress surface, dressing equipment, bariatric bed):

_____

ADL's / Mobility (Mechanical lift? Up in chair daily?) _____

Falls history: ☐ Y ☐ N if yes, last fall date: _____

Psychological / Psychosocial (i.e. depression, anxiety, behaviours?): _____

_____

Has the discharge plan been initiated? ☐ Y ☐ N

If yes, discharge to : ☐ Home Independently ☐ Home with Support

☐ LTCH name:

☐ RH name:

Home setup (i.e. multilevel, apartment, etc.) :

Prior Home Care Supports:

Are discharge concerns anticipated? ☐ Y ☐ N

Describe:

CONTACT INFORMATION

Bed offer Contact Name : Bed Offer Contact # :

Contributor	Designation	Contact #	Date

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VENTILATOR SETTINGS AND OXYGEN THERAPY SETTINGS

Respiratory: Vent Schedule (Please check) : ☐ **Continuous** ☐ **Nocturnal** ☐**Intermittent**

Ventilator	Settings	Trach / Oxygen Therapy	
Vent Mode and Type (i.e. Astral / Trilogy)		Tracheostomy Information	**Type :** ☐ **Cuffed** ☐ **Uncuffed** If cuffed, any time deflated? :
Mandatory Breath type (Br / min)		Oxygen Equipment, i.e. Airvo / High flow, HH	
Respiratory Rate Set (Br / min)		Oxygen Therapy	**Rate : Fi02** _____ (L) _____
Tidal Volume Set (mL) – If applicable		Speaking valve or cork?	
Pressure Control (Delta Set) (cmH20)		Suctioning frequency	
Positive End Expiratory Pressure (cmH20)		Cough assist or Breath stacking	
Inspiratory Time (seconds)		Tracheostomy first change must be done before admission	**First Trach change date:** _____ **Next one due:** _____
Fi02 Set / 02 Flow (L / min)			

Additional Notes / Comments: _____

_____

_____

_____

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Waterloo Regional Health Network (WRHN)- Chicopee Campus

Complex Medical/Long Term Vent Unit Referral

Criteria Checklist

- All acute conditions necessitating acute care/ICU admission have been stabilized or resolved for at least 72 hours (may require more under certain circumstances, i.e. repeated issues)
- Continuous vital signs monitoring is no longer required and discontinued for at least 72 hours
- Primary ventilator settings consistent for the past 7- 14 days **(Chicopee Only)**
- First trach changes planned or done before transfer
- Medications consistent for the past 7- 14 days
- Stable tracheal suctioning frequency – no more than q3 hours
- Maximum allowable PEEP/EPAP of 12 cmH2O (for any PEEP > 10 please provide details) **(Chicopee Only):** _____
- Maximum allowable FiO2 of 0.40
- Patient no longer requires 1:1 nursing; can be safely cared for in a 1:3 or greater nursing to patient ratio
- Routine or scheduled monitoring of bloodwork can be accommodated
- Patient takes food orally or has a permanent feeding source, i.e. PEG tube
- For patients that require dialysis: uncomplicated/stable runs which Chicopee can support
- An established, effective treatment plan for physical and mental health disorders
- Age: 18 years and above (patients (16 – 17 years) please contact the program directly to discuss consideration)
- Patient and family goals of care and expectations of the program align with what can be offered (both routinely and in medical emergencies) and are in keeping with the patient's diagnosis/disease trajectory

If the patient does not meet the above guidelines, please call **** to discuss further.

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Patient Name:

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LETTER OF UNDERSTANDING

_____ (Insert patient's name), your current care needs no longer require an acute hospital setting. The health care team has noted that your needs may be met within the services offered in a complex continuing care program. These programs are regional programs, offered at multiple sites within WaterlooWellington:

☐ Complex Medical
☐ Chronic Ventilator

Site	Complex Medical Management	Chronic Ventilator / Respiratory Program
Waterloo Regional Health Network @Chicopee in Kitchener	✓	✓
St. Joseph's Health Centre Guelph	✓	N/A

You will be notified by your health care team when a bed becomes available for you. The first available bed may be located at any one of the locations listed above. The health care team will assist you in arranging the transfer to the accepting complex continuing care program.

Referrals are coordinated by Ontario Health atHome Waterloo Wellington. Your health care team will be sharing your medical and personal information with Ontario Health atHome WW and the complex continuing care program. Ontario Health atHome WW will add your name to the waiting list. Your initials and gender will be accessible to Ontario Health atHome WW's other hospital partners.

Patient's initials:

I have reviewed and understand the above information. I agree to proceed with the referral for the rehabilitative care program. I understand that my personal and health information will be shared with Ontario Health atHome WW and the rehabilitative care sites within the region.

Patient Name :

Patient/Substitute Decision Maker's (SDM) Signature :

Print SDM Name:

Date :

Verbal / telephone agreement Documentation (if signature not possible)

Date :

Consent Obtained From:

Signature of Staff Member :

Printed Name of Staff Member obtaining consent :