SUPPLEMENT C – RESPIRATORY / BREATHING ASSISTANCE

Please complete this Supplement only if you indicate you need **Respiratory or Breathing Assistance** on page 4 of the Application ((Section IV, Service Needs).

In addition, a typed clinical/medical summary must be included with this form.

Applicant Name:	
Health Card (OHIP) #:	
Treating Respiralogist:	**Phone:**
Family Physician:	**Phone:**
Primary Diagnosis (including date of onset):	
Other Medical Conditions:	
Medically Stable? YES ☐ NO ☐	
Advance Care Directives:	

NUTRITION -
What method of feeding is used? ☐ Oral feeds ☐ Tube feeding If so, what type?
What is your feeding routine?

EQUIPMENT – please identify any equipment owned by/rented for the client.	
☐ Ventilator/Bipap/Cpap	☐ Apnea monitors
☐ Portable suction unit	☐ In/exsufflator
☐ Manual resuscitator (Ambubag)	☐ Back-up power source
☐ Battery chargers	

DISCHARGE PLANS: ***Note to referring facility: Any difficulties in completing this section can be discussed with your preferred service provider.***

Are you returning to:

☐ private home ☐ assisted living / supportive housing

☐ Other. Please state:

Caregivers – ***caregivers are those persons who provide all necessary care in the home (eg family member(s), friends, other paid staff or similar). Caregivers will always be necessary when the client is physically unable to care for themselves, i.e. client is quadriplegic or has severe neuro-muscular deficits rendering him/her unable to care for themselves.***

Please provide the names of Caregivers that are trained to your respiratory care needs, and their relationship to you.

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____

→ **Access to Environment**

Can you use the following independently?

TV/Stereo YES ☐ NO ☐

Computer/Tablet/IPad YES ☐ NO ☐

Telephone YES ☐ NO ☐

If **NO**, what emergency system do you have in place? Please specify:

→ **Attendant Service Provision** - ***support service at home will be by staff who are supervised by registered nursing staff.***

Who will be responsible for providing client-specific respiratory training to the Attendants?

Respiratory Therapist ☐ Physician ☐

Other (pls indicate**):**

Optimal transition from hospital to home includes the opportunity to train Attendants on your respiratory routine while in hospital, before discharge.

Will there be opportunity for staff to be trained on your respiratory routine while you are in hospital?

YES ☐ **NO** ☐ If **NO**, please explain:

TRACHEOSTOMY -

Trach Tube Type / Size:

☐ Cuffed Cuff volume: _____ ☐ Uncuffed

☐ Fenestrated ☐ Unfenestrated

Date of recent Trach Tube Change:

Trach Changes Performed by (ie physician, RRT):

Frequency of Trach Changes:

Stoma Condition:

If you have vent-free time, are you able to tolerate cuff deflation or corking?

YES ☐ NO ☐

Comments:

DIAPHRAGMATIC PACING -

Model:

Bilateral Pacing YES ☐ NO ☐ **Unilateral Pacing** YES ☐ NO ☐

Respiratory Rate: _____ bpm

Right Ampl: _____ Left Ampl: _____

How long have you used pacers? _____

Hours of use /24 hours?: _____

SUCTIONING -

Frequency:

Do you require assistance to suction?

Trach **YES ☐ NO ☐**

Oral **YES ☐ NO ☐**

Have you had a swallowing assessment, including videofluroscopy?

YES ☐ NO ☐

Do you have a problem with aspiration? YES ☐ NO ☐

If YES, please describe:

VENTILATION NEEDS -

Ventilation start date:
How many hours/day are you using mechanical ventilation?
Do you know your ventilator settings? YES ☐ NO☐
Are you able to breathe on your own (off the ventilator)? **YES ☐ NO ☐** **If YES, how long are you able to breathe on your own?**
Is oxygen required while ventilated? YES ☐ NO ☐
Is oxygen required while you are breathing spontaneously? **YES ☐ NO ☐**
→ Ventilator Settings
Current Ventilator Model:
Mode of Ventilation:
Ventilator Settings: V_T _____ c.c. FiO_2 _____ Pressure Control _____ cmH_2O PEEP _____ cmH_2O R.R. _____ bpm Pressure Support_____ cmH_2O
Date of recent Arterial Blood Gas (ABG) results on the above settings?

MANUAL VENTILATION -
Do you require assistance bagging? YES ☐ NO ☐
What is your ambu-bagging routine?
Any additional comments?