Holland Bloorview
Kids Rehabilitation Hospital

150 Kilgour Rd. Toronto, ON M4G 1R8
Tel: (416) 753-6022
Fax: (416) 422-7036

# SLEEP & VENT ASSESSMENT REFERRAL FORM

**Referring Hospital/ Clinic:**

☐ SickKids ☐ McMaster Children's ☐ London Children's ☐ CHEO ☐ Holland Bloorview Neuromuscular Clinic

☐ Other:_____

**Key Team Contact:**_____

Team Contact/Key Worker Contact#:_____Email: _____

Preferred Method of Communication: ☐ Phone ☐ Email

Referring Provider Contact#:_____ OHIP Billing Number:_____

MRP:_____ Contact#:_____

**Information**

Client Name: _____

Chosen Name: _____ Birth Sex: ☐ Female ☐ Male ☐ Unknown

Gender: ☐ Female ☐ Male ☐ Non-Binary ☐ Other ☐ Unknown/Undifferentiated

Preferred Pronouns: ☐He/Him/His ☐She/Her/Hers ☐They/Them/Theirs ☐He/They ☐She/They ☐Ze/Zir

Child's Primary Address: _____

City: _____ Postal Code:_____

Date of Birth (Day/Month/Year): _____

OHIP: ☐ No ☐ Yes, OHIP#:_____ Version Code: _____

If No, Please Explain:_____

Caregiver Name: _____ Relationship to Child: _____

Caregiver Contact#: _____

Interpreter Required:_____ ☐ No ☐ Yes If yes, for whom: _____

☐ Language Spoken:_____

**Information**

**Primary Diagnosis:**_____

Secondary Diagnosis(es):_____

Isolation d/t Infection Control: ☐ No ☐ Yes If yes, isolation type & organism:_____

_____

☐ **Current Medical History:** Please attach a brief medical history or recent medical summary

☐ **Current List of all Medications:** Please attach a complete medication list **or** complete the Client Medication Profile (page 4)

Allergies: ☐ No ☐ Yes If yes, please describe:_____

_____

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**Reason(s) for Referral (please indicate all that apply)**

☐ Suspected hypoventilation

☐ Suspected sleep-disordered breathing

☐ Monitoring & titration with well-established tracheostomy and ventilator use

☐ BiPAP initiation, titration or assistance with compliance

☐ Sleep Screen (transcutaneous carbon dioxide monitoring and overnight oximeter

☐ Other, Please Describe: _____

_____

**Nutrition/Diet**

**Oral Feeding:** ☐ No – NPO

☐ Yes – Expressed Human Milk (EHM)/ formula

☐ Yes - Regular Diet ☐ Yes - Special Diet Please describe type of diet and feeding schedule:

_____

_____

_____

**Enteral and Parenteral Nutrition Support:**

☐ NG-tube ☐ OG-tube ☐ G-tube ☐ G/J tube

☐ Other, Please Describe: _____

_____

_____

Date of insertion: _____

Delivery: ☐ Pump ☐ Gravity

Feeding schedule and type (EBM, formula and name concentration, rate, flushes): _____

_____

_____

**Anticipated Interventions Required**

| | Type | Frequency |
|---|---|---|
| ☐ **Imaging:** | | |
| ☐ **Blood Work:** | | |
| ☐ **Other:** | | |

**Access for Blood Work:**

☐ Phlebotomy ☐ Central Line

**Skin Condition:**

☐ Normal ☐ Wound/Incision ☐ Burn

☐ Stoma Care Specialized Dressings

☐ Specialized Surface

Type: _____

☐ Other, Please Describe: _____

_____

**Other Needs:**

Specialized Rehabilitation Equipment: ☐ No ☐ Yes

Complementary Therapies: ☐ No ☐ Yes

Please Describe: _____

_____

_____

_____

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**Anticipated Interventions Required:**

**Seizure Activity**

☐ No ☐ Yes, if yes, ☐ Pre-existing ☐ New onset

Describe Seizures: _____

_____

Describe Seizure Management: _____

_____

**Medical Assistive Technology Anticipated at Time of Admission**

☐ Oxygen ☐ Suction ☐ Tracheostomy, Type:_____ Size:_____ Date of Insertion:_____

☐ Invasive via tracheostomy (IPPV) ☐ Non-invasive (NIPPV e.g. BIPAP) ☐ CPAP ☐ Nocturnal only ☐ 24hrs

☐ Airvo ☐ In/exsufflator

☐ CVC/PICC line/Port: Size:_____ Length:_____ Date of Insertion:_____

☐ VP Shunt ☐ Vagal Nerve Stimulator ☐ Dialysis ☐ Insulin Pump

☐ **Clinic Notes:** Include all ventilator settings, information related to oxygen use, and cough assist orders as appropriate

☐ Other:_____

_____

**School** ☐ No ☐ Yes, School Name:_____ Grade:_____

**Psychosocial/Behaviour Issues**

Safety Risks (e.g. falls/wandering/aggression/substance misuse) ☐ No ☐ Yes If yes, please describe: _____

_____

Safety Strategies (e.g. behavioural plan):_____

1:1 Supervision: ☐ No ☐ Yes If yes, type: ☐ PSW ☐ CYW ☐ Observers/Sitters ☐ Security

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***If assistance is required in completing this form, please contact Coordinator, Access and Flow: 416-425-6220 x 7359**

## Client Medication Profile

**Client Medication Profile**

| | |
|---|---|
| Allergies | |
| Reaction to allergies? | |
| Epi-pen required? | |

| Medication name, strength & dosage form | Dose | Route | Frequency | Comments |
|---|---|---|---|---|
| | | | | |
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| | | | | |
| Complementary and alternative medicines | | | | |
| Substance use/medicinal marijuana | | | | |
| Hazardous/cytotoxic medications that requires special handling | | | | |

Key Contact for Medication-Related Issues / Contact #: _____

_____