Print Form

Patient's Vital Information for Medical Staff

To be used along with
Treating Neuromuscular Patients Who Use Home Ventilation: Critical Issues

MY INFORMATION

Patient _____ Birth Date _____

Medic Alert ID # _____

Company Name _____

Company Phone _____

Neuromuscular condition _____ Age at onset _____

If trached, age when occurred _____ If noninvasive ventilator use, age when began _____

Ventilatory assistance is needed _____ hr/day and _____ hr/night, or _____

If scoliosis, degree of curvature _____

Health facility of choice when stable _____

Important! **My caregiver(s) and I are extremely knowledgeable about my condition, treatment needs, and equipment. Please work with us.**

Authorization to Speak with Caregiver(s)

I need my caregiver(s) to be with me during my entire treatment and ***I authorize you to consult with my caregiver(s)*** *(family, friend or home health personnel)* with no privacy or timeframe restrictions.

Caregiver Name _____ Phone _____

Caregiver Name _____ Phone _____

Caregiver Name _____ Phone _____

Patient Signature _____

Date _____

How I Communicate

- ☐ Speech
- ☐ Via speaking device
- ☐ With a bell
- ☐ In writing
- ☐ Via my caregiver
- ☐ Other _____

Important!

☐ **I use noninvasive ventilation**. If intubation or a tracheotomy is proposed, please consult me, my caregiver, and my physician listed in the "My Health Professionals" section.

☐ **I have a tracheostomy.** It is critical that you consult me regarding the details of my routine.

Patient _____

MY HEALTH PROFESSIONALS

You have my permission to contact, at any time, these health professionals who have agreed to consult.

PHYSICIAN #1

Name _____ Specialty _____

Comments _____

Signature _____ Phone _____ Date _____

PHYSICIAN #2

Name _____ Specialty _____

Comments _____

Signature _____ Phone _____ Date _____

PHYSICIAN #3

Name _____ Specialty _____

Comments _____

Signature _____ Phone _____ Date _____

Respiratory Care Practitioner (RCP) – *Please direct hospital RCP to consult with this RCP.*

Name _____ Phone _____

Home Health Company _____ Phone _____

Instructions: _____

_____

Signature _____ Date _____

For additional specialists available to consult in relation to neuromuscular patients who use ventilators, see last page of this document or go to www.ventusers.org/net/ventDIR.pdf.

MY TREATMENT

OXYGEN: I require supplemental oxygen ☐ Never ☐ Always ☐ Part Time

Caution! **Providing oxygen to me may have dire consequences!**
Oxygen used alone may mask or accelerate acute respiratory failure in neuromuscular patients. The response to low oxygen levels must be to increase ventilatory support and secretion management, NOT simply to administer oxygen.

Administer oxygen to me ONLY if all four of these conditions are met.

- I have an additional pulmonary condition such as pneumonia, COPD or pulmonary embolism, ***and***
- My O_2 saturation is below 90% ***and***
- Secretion management, e.g., CoughAssist® or air stacking, has failed to improve saturation levels ***and***
- My mechanical ventilation is securely in place.

Then provide only low levels of oxygen and monitor CO_2 levels. Oximetry and $EtCO_2$ (End Tidal) are preferable and adequate for measurement.

Patient _____

ANESTHESIA/SEDATION

I must be ventilated before I am given sedation/pain medication. ☐ Yes ☐ No

I can tolerate _____

I've had negative reactions to _____

Caution! **Anything that depresses respiratory drive must be used with great caution.**
See Treating Neuromuscular Patients Who Use Home Ventilation: Critical Issues.

MY ALLERGIES

_____

_____

MY TYPICAL VITALS *(These can change during ventilation and position change.)*

Blood pressure _____ Sitting Vital Capacity _____ %N ___ Oxygen Saturation _____

Temperature _____ Supine Vital Capacity _____ %N ___ Carbon Dioxide Level _____

Peak Cough Flow _____

Other _____

MY POSITIONING

Without ventilatory assistance I am at mortal risk in these positions _____

_____

My best positions are _____

MY EQUIPMENT

I prefer to use my home equipment. (If applicable, hospital pre-approval is attached.)
If use of home device is not feasible, hospital's equivalent is second best.

FOR VENTILATION

I require breathing assistance for _____ hrs/day and _____ hrs/night, or

Other _____

My breathing machines/ventilators include

#1 Type and Model _____

Manufacturer _____

Settings

Mode ☐ Assist Control ☐ Pressure Support ☐ SIMV (combination)

Inspiratory Time _____ Breathing Effort (BPM) _____ PEEP _____ Sensitivity _____

Low Pressure Limit _____ High Pressure Limit _____ Alarm: High _____ Low _____

Tidal Volume _____ Rate _____ IPAP _____ EPAP _____

Other _____

Patient _____

#2 Type and Model _____

Manufacturer _____

Settings

Mode ☐ Assist Control ☐ Pressure Support ☐ SIMV (combination)

Inspiratory Time _____ Breathing Effort (BPM) ____ PEEP _____ Sensitivity _____

Low Pressure Limit _____ High Pressure Limit _____ Alarm: High _____ Low _____

Tidal Volume _____ Rate _____ IPAP _____ EPAP _____

Other _____

MY INTERFACE(S) for access to my breathing machine/ventilator include

☐ Nasal Mask ☐ Nasal Pillows ☐ Trach Tube *(See detail below.)*

☐ Face Mask ☐ Mouthpiece ☐ Custom-made Mask

Model _____ Size _____ Manufacturer _____

Model _____ Size _____ Manufacturer _____

Model _____ Size _____ Manufacturer _____

Trach Tube details

Fenestrated? ☐ Yes ☐ No

Cuffed? ☐ Yes ☐ No If yes, inflation is: Day @ _____ cc Night@ _____ cc

FOR HUMIDITY, I use _____

_____

FOR SECRETION MANAGEMENT, the most effective methods for me are

☐ CoughAssist® – Inhalation _____ Exhalation _____ # Breaths _____

☐ Suctioning – Depth _____ Frequency _____ Catheter Size _____

☐ Postural Drainage – Method _____

☐ Bagging _____

☐ Percussor – Locations _____ Times/Minutes _____

FOR FEEDING/NUTRITION, I use

_____

_____

MY BOWEL ROUTINE is

_____

_____

Patient _____

MY CURRENT MEDICATIONS

BRAND NAME	GENERIC NAME	Dosage & Frequency	PURPOSE	When Begun	How Long Used	SPECIAL INSTRUCTIONS

This document belongs to

Name _____

Address _____

City_____State_____ Country_____

Email _____ Phone _____ Fax _____

I have read and approved the contents of this document.

Ventilator User Signature _____ Date _____

Witness Signature _____ Date _____

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