



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

- | | |
|--|---|
| <input type="checkbox"/> Speech | <input type="checkbox"/> In writing |
| <input type="checkbox"/> Via speaking device | <input type="checkbox"/> Via my caregiver |
| <input type="checkbox"/> With a bell | <input type="checkbox"/> 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 O₂ 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 CO₂ levels. Oximetry and EtCO₂ (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

Contributors Including Specialists Available for Consult

Brenda Jo Butka, MD

Respiratory Care, Pulmonology
Vanderbilt Stallworth Rehabilitation Hospital
Nashville, Tennessee
615-963-4488, 615-963-4002 fax
brenda.butka@vanderbilt.edu

Helen A. Kent, RRT, BS

Progressive Medical
Carlsbad, California
800-491-2292, **760-448-4448**, 760-448-4449 fax
hkent@progressivemed.org
www.progressivemed.org

Noah Lechtzin, MD, MHS, FCCP

Pulmonary & Critical Care Medicine
Johns Hopkins University
Baltimore, Maryland
410-502-7044, 410-502-7048 fax
nlechtz@jhmi.edu

Lou Saporito, RRT, BS

Millennium Respiratory Services
Whippany, New Jersey
800-269-9436, **973-463-1880**
saporilr@umdnj.edu

Augusta S. Alba, MD, Retired

Consultant, Rehabilitation Medicine
Coler Goldwater Specialty Hospital and Nursing Facility
Roosevelt Island, New York

Linda L. Bieniek, LaGrange, Illinois

Mary Ann and William (deceased) Buckingham, Worth, Illinois

Jason Hallgren, Coatesville, Pennsylvania

Valerie and Richard Parrish, Plainfield, Illinois

Carol Wallace, Austin, Texas

Christamae Zimpel, Ceres, California

Prepared by

IVUN
International Ventilator Users Network
An affiliate of Post-Polio Health International (PHI)

Funded by

 Paralysis Resource Center
Christopher and
Dana Reeve Foundation