BC HOME PARENTERAL NUTRITION (HPN) PROGRAM APPLICATION (ADULT PATIENTS)

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Referral Other

This application form must be completed and faxed with all required documents to 604-806-8044

Referring physicians/clinicians and patients are welcome to contact the HPN coordinator at 604-806-9808 for any questions regarding the application processor patient agreement/program requirements.

There are 4 pages in this application form:

1. "Does your patient qualify for the program?" and Referring Physician Information
2. Patient Demographics, Location, Nutrition Treatment and Professional Contact Information
3. Patient and/or Caregiver Agreement
4. Application Document Checklist

DOES YOUR PATIENT QUALIFY FOR THE PROGRAM?

Answering "YES" to ALL questions below indicates an appropriate referral to the program.	YES	NO
Patient is unable to receive adequate nutrition via oral and/or enteral routes.		
Patient and/or designated caregiver has the capacity to perform HPN:		
a) Cognitive capacity (*e.g. must be able to follow steps in procedure and troubleshoot pump alarms)*		
b) Manual dexterity *(e.g. must be able to remove caps from small bottles)*		
c) Visual acuity *(e.g. must be able to read small print on medication bottles)*		
d) Reading comprehension of English language *(e.g. must be able to read infusion pump)*		
Patient is medically and functionally stable and their need for parenteral nutrition is the only care requirement keeping them in the hospital.		
Patient is not taking parenteral antiemetics or narcotics. Oral antiemetics, oral narcotics and fentanyl patches are acceptable. ****(under exceptional circumstances, some terminally ill patients may be considered)***		
Patient and/or caregiver has a desire to be a part of the Program and is willing to be actively engaged in the full requirements of the Program (*refer to Patient Caregiver Agreement)*		
Patient will have an anticipated, minimum of 3 months of quality life on HPN.		
Patient and/or caregiver has received teaching on all non-HPN related tasks as relevant (*e.g. ostomy, fistula, wound or diabetic care*).		

***Please see the following link for additional details regarding parenteral medications & HPN:**

http://www.bchomenutrition.org/home-parenteral-nutrition.html

***Parenteral Medications & HPN**

The use of parenteral medications is strongly discouraged for the following reasons:

- Frequent access of the patient's vascular access device increases the risk of line breakage and/or line sepsis
- Some parenteral medications lead to extreme drowsiness, thereby compromising patient safety when administering HPN
- The program does not pay for parenteral medications or supplies required. Please note that most parenteral medications and administration supplies are not covered by PharmaCare.
- To avoid risk of parenteral narcotic misuse

Under very exceptional circumstances, some terminally ill patients who are on parenteral narcotics and approved for coverage under the Palliative Care Benefits Program may be considered.

Please ensure that your patient is medically and functionally stable before submitting an application. If the application is more than 3 months old, you may be asked to resubmit this page with the patient's most recent clinical information.

REFERRING PHYSICIAN:

If following a period of stay at St. Paul's Hospital, this patient is unable for any medical or other reasons to return home, or the patient is deemed to be not safe to administer HPN, I agree to admit this patient back to this hospital.

Name (PRINT): _____ **MSP #:** _____

Signature: _____ **Date**: _____

Phone: _____ **Fax**: _____

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PATIENT INFORMATION		
Name: (last, first)		DOB: (dd/mmm/yyyy)
Address (Street, Apt, Buzzer #):		Gender: ☐ Male ☐ Female ☐ Other:
City:	Province:	PHN:
Postal Code:		Email:
Home phone number:		
Alternate contact person:	Relationship:	Phone number:
Health Benefits: ☐ First Nations & Inuit Health Benefits ☐ BC Palliative Care Benefits ☐ Other:		
PATIENT'S CURRENT LOCATION: ☐ Home ☐ Hospital		
Facility:		
Ward:		Room:
Phone:	Extension	Fax:

CURRENT NUTRITION TREATMENT

Date measured (dd/mmm/yyyy):_____ Patient's Height: _____

Patient's Weight: _____ Percent weight loss: _____ Time frame:_____

Is the patient currently on TPN? ☐ Yes ☐ No **If yes, please send a copy of current TPN prescription with application**

TPN Access: ☐ No CVC in situ ☐ PICC Tunneled: ☐ Hickman ☐ Groshong IVAD: ☐ Valved ☐ Non-Valved

Number of Lumens: ☐ Single ☐ Double Is patient NPO? ☐ Yes ☐ No

If no, describe current diet type: _____

Has patient received diet education? ☐ Yes ☐ No

If yes, list diet information given to patient: _____

Describe any dietary modifications that have been tried and their results: _____

_____

Has enteral nutrition (EN) been trialed? ☐ Yes ☐ No If yes, Formula: _____ Rate:_____

Results of EN trial: _____

If no, please indicate reason: _____

ISOLATION REQUIREMENTS

☐ MRSA ☐ VRE ☐ TB ☐ Other: _____

OTHER

Are there any psychosocial issues that may contraindicate home TPN for this patient? _____

_____

PROFESSIONAL CONTACT INFORMATION:

Current Dietitian:_____ Phone: _____

Family Physician: _____ Phone: _____

Specialist Physician: _____ Phone: _____

Providence Health Care

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This letter is to be reviewed and signed by the patient **AFTER** they have been informed about the BC HPN Program and TPN in general.

**** If a caregiver is required to assist the patient with HPN procedures, they must also read and agree to participate in all aspects of the program.***

There are many skills that you will need to learn in order to give yourself HPN. Learning these skills takes time and practice. Each day you will have teaching sessions with a nurse. Before you leave St. Paul's Hospital, you will need to show that you can do all the skills on your own.

You will be responsible for the following:

- Coming to St. Paul's Hospital for a 2 to 3 week teaching program.
  (1 to 2 teaching sessions daily, Monday to Friday between 8 A.M to 4 P.M
  *If applicable, caregivers must also be available for scheduled sessions.
- Learning to care for a central line and give yourself nutrition fluid through a tube into your vein (intravenous nutrition).
- Remaining off parenteral (IV, IM, subcutaneous) medications.
- Having regular visits with your family doctor and your HPN doctor.
- Having bloodwork done at least every month.
- Having regular telephone calls with the BC HPN program.
- Ordering your HPN Supplies.
- Making arrangements for returning home after HPN training is complete.
- Devoting adequate time to be educated in the safe practices related to care and central line intravenous infusions.

You will need to learn the following skills:

- Handwashing.
- Cleaning of work area and setting up of work area and supplies.
- Being confident and safe with needles and syringes.
- Keeping supplies organized and clean on work area – maintaining aseptic technique.
- Flushing of central line; unhooking TPN.
- Accessing implanted central line with an access needle (if applicable).
- Changing central venous catheter dressing and positive pressure cap weekly.
- Adding Multivitamins, Ranitidine, and/or Vitamin K to TPN bag (if applicable).
- Programming of TPN pump, priming TPN tubing, and infusing of TPN with use of pump.
- Using gravity method of infusion for hydration.

I have read the HPN program agreement and consent to participate in the BC HPN program. I have been given the opportunity to ask and get answers for my questions. I understand and agree that failure to adhere to this agreement may result in the inability of the HPN program to safely care for my medical needs. Which may result in my PN and TPN-associated supplies being placed on hold until assessment can be completed. I also understand that while HPN supplies are funded by the BC HPN Program, I am responsible for paying/ensuring coverage for all non-HPN related supplies. e.g.) ostomy, fistula, wound, diabetic supplies and other medication supplies.

Patient Signature: _____ Caregiver Signature (if applicable):_____

Patient Printed Name: _____ Caregiver Printed Name: _____

Date: _____ Date: _____

Give a copy of this page to the patient/caregiver.

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APPLICATION DOCUMENT CHECKLIST

Please ensure ALL of the following documents are included as part of the application:

- ☐ Fully completed PATIENT APPLICATION (page 1 & 2)
- ☐ DICTATED PHYSICIAN MEDICAL SUMMARY which includes the following:
  - Summary must be "Up to Date" (within the past week)
  - In your dictated summary, please comment on each section and number as follows:
    1. Indication for Home Parenteral Nutrition/cause of intestinal failure, including primary GI diagnosis
    2. If the patient has short bowel syndrome (SBS), estimated length of remaining small bowel
    3. History of previous bowel resections (attach operative notes)
    4. Current ostomy output and/or other GI losses. Please describe any attempts/successes to decrease GI losses
    5. Concomitant medical illnesses – liver, kidney, heart disease, etc.
    6. Narcotic usage – please note, PO or transdermal are the preferred route for narcotic administration for HPN patients., Use of parenteral narcotics is an exclusion criteria for the program (see page 1 for more information)
    7. Other parenteral medications – please note, parenteral medications (e.g. IM, IV, subcutaneous) are not covered under this program and are strongly discouraged (see page 1 for more information)
    8. Current or previous drug or alcohol abuse
    9. Any concerns the medical staff may have about the patient going home such as:
       - lack of-social support
       - cognitive impairment
       - functional limitations
       - poor manual dexterity
       - visual impairment
       - medical issues precluding training and/or discharge home
- ☐ Patient and/or Caregiver Agreement reviewed and signed by patient (see page 3). Please retain a copy for patient and/or caregiver.
- ☐ ALL Operative Notes of abdominal surgery
- ☐ If the patient has a central line, report of central line insertion, including: device location, device tip location, brand/size, insertion date and name of physician who inserted the line.
- ☐ Copy of Medication Administration Record (MAR)
- ☐ Copy of current TPN prescription
- ☐ Copy of nutrition assessment and current nutrition care plan
- ☐ Information on isolation requirements (e.g. MRSA, VRE, TB, etc.)
- ☐ Copy of Caution Sheet or a list of allergies

Please fax the completed application form, patient/caregiver agreement and all required documents to the BC Home Parenteral Nutrition Program

Fax: 604-806-8044

After submission, you will be contacted by the BC HPN Program Coordinator within 2 business days to acknowledge receipt of the application. If you do not receive this acknowledgement, then the application has not been received.

Please contact the BC HPN Program Coordinator at 604-806-9808 if you would like to discuss the application further or confirm receipt.