**PWC RAPID SCREENING FORM**

Insert Patient ID Sticker

|  |  |
| --- | --- |
| C:\Users\lista\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\51VFCBB4\MGH logo.jpg Prolonged-ventilation Weaning  Centre (PWC) of Excellence  Phone: 416 469 6580 ext. 6841  Fax: 416 469 7717  prolonged.Ventilation@tehn.ca |  |

**Please check boxes for potential PWC candidates**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Question** | Yes | No |
| **Respiratory** | Has been invasively mechanically ventilated (MV) |  |  |
| Date of initiation of MV |  |  |
| Would they be capable of spontaneous mode of ventilation? |  |  |
| Has or is being considered for tracheostomy insertion |  |  |
| If yes, date of insertion? |  |  |
| If yes, are they participating in trach mask or optiflow trials? |  |  |
| **Neurological** | Is awake and able to respond appropriately to questions |  |  |
| Would be able to operate a standard call bell |  |  |
| If physical or chemical restraints in use, please describe indication |  | |
| **Cardiovascular** | Does not currently require vasopressors or inotropes |  |  |
| **GU** | Does not require dialysis? |  |  |
| **GI** | Has or is being considered for a PEG tube for enteral diet? |  |  |
| **Goals of Care** | Patient and/or substitute decision maker consents to PWC consultation |  |  |
| Current code status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

**If you are able, please describe briefly the reason for ICU admission:**

**If you are able, please describe briefly the patient’s medical comorbidities**