Catch the New Jersey WAVE

WONDERFUL ADOLESCENT VENTILATOR EXCURSION

PARTICIPANT APPLICATION

ALL INFORMATION COLLECTED WILL REMAIN PERSONAL AND CONFIDENTIAL

GENERAL INFORMATION

Child's Full Name: _____ D.O.B.: _____ Sex: M☐ F☐

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Parent/Guardian: _____

Allergies: _____

Diagnosis: _____

RESPIRATORY STATUS

Ventilator Name: _____ Mode: _____

Tidal Volume: _____ IPAP: _____ Rate: _____ PEEP/CPAP: _____

FIO2: _____ Pressure Limit: ☐ High ☐ Low

Alarm: _____ Weans to (mode): _____

Weans for (how long): _____

TRACHEOSTOMY

Brand: _____ Size: _____ Type: ☐ Pediatric ☐ Adult

Speech Valve: ☐ Yes ☐ No

Aersol/MDI Dose: _____ Aersol/MDI Frequency: _____

Airway Clearance (CPT,in-exsufflator, etc...):

_____

_____

_____

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MEDICATIONS

Medication: _____

Dose: _____ Frequency: _____

Medication: _____

Dose: _____ Frequency: _____

Medication: _____

Dose: _____ Frequency: _____

Medication: _____

Dose: _____ Frequency: _____

Medication: _____

Dose: _____ Frequency: _____

Medication: _____

Dose: _____ Frequency: _____

Medication: _____

Dose: _____ Frequency: _____

Medication: _____

Dose: _____ Frequency: _____

Medication: _____

Dose: _____ Frequency: _____

NUTRITION

Diet Type: ☐ Regular ☐ Pureed ☐ Baby Food ☐ Formula ☐ Thin Liquids ☐ Thick Liquids

Liquids: _____

Special Feeding Needs:

Equipment: _____

Techniques: _____

Positioning: _____

Tube Feeds: ☐ NG ☐ GT Water Amount: _____ Water Frequency: _____

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ELIMINATION

Voiding Pattern: _____ Voluntary Diapers: ☐ Yes ☐ No

CIC: _____ Frequency: _____

CIC Catheter Type: _____ CIC Catheter Size: _____

Bowel Pattern: _____ Voluntary Diapers: ☐ Yes ☐ No

Bowel Program: _____

MOBILITY

Ambulatory: ☐ With assistive devices ☐ Without assistive devices

Assitive Device Type: _____

Use of Orthosis(MAFOs,KAFOS,TLSOs ect.): _____

Bed Type: ☐ Hospital Bed ☐ Regular Bed ☐ Crib ☐ Special Matress

Turns Self: ☐ Yes ☐ No Turns every hours: _____

Positioning Equipment Needs: _____

Weight (lbs): _____

ACTIVITIES OF DAILY LIFE PARTICIPATION

Participates in self-care activities: ☐ Independent ☐ With Assistance ☐ Total Assistance

Describe self-care activities independently completed:

_____

_____

ADL Adaptive Equipment Needs:

_____

_____

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HOME EQUIPMENT (BRAND AND MODEL)

Apnea Monitor: _____ Pulse Oximeter: _____

Portable Suction: _____ Feeding Pump: _____

Air Compressor: _____ Humidifier: _____

Home Oxygen Liquid: _____

Concentrator: _____

Portable Oxygen Liquid: _____

Cylinders: _____

Other Equipment: _____

COMMUNITY CARE PROVIDERS

Home Case Manager: _____ Phone: _____

Homecare Agency: _____ Phone: _____

Medical Equipment: _____ Phone: _____

Physician: _____ Phone: _____

ACTIVITIES/EDUCATION

Education Level: _____ Grade: _____

Means of Communication: _____

Activities of Interest: _____

Level of participation: ☐ Independent ☐ With Assistance ☐ Total Assistance

Adaptive Recreational Equipment Needs: _____

Describe Child's Social Skills:

_____

_____