 <p>Winnipeg Regional Health Authority Office régional de la santé de Winnipeg Caring for Health À l'écoute de notre santé</p> <p>COMMUNITY HEALTH INFORMATION FORM COMPLETION GUIDELINE</p>	Form Name: Home Care Request for Therapeutic Sleep Surface	Form Number: WCC-00178
	Approved By: Community Health Information Committee Home Care Forms Committee	Pages: 1 of 2
	Approval Date: Jan 31/14	Supersedes: Sept. 30, 2013

INTENT/PURPOSE OF FORM

- The Home Care Request for Therapeutic Sleep Surface form is used to identify clients who are at risk for the development of pressure ulcers, have existing skin ulcers or who have pain management concerns that require assessment for eligibility of Winnipeg Regional Health Authority Home Care to provide a Therapeutic Sleep Surface.

DEFINITIONS


- Therapeutic Sleep Surface: a mattress/overlay that is used in the treatment of skin ulcers, or to prevent the development of skin ulcers.

USED BY

- Home Care Case Coordinators and Home Care Direct Service Nurses.
- Program Consultant for WRHA Home Care.

GUIDELINES FOR COMPLETION OF FORM

- Client Demographic Box: client's demographic box in upper right hand corner of form is to be **completed in full**. Client label can be affixed.
- Client Phone/City/Postal Code Box: please add additional contact information here.
- Instructions for Additional Documents Required: follow these instructions to ensure that the designated staff complete all applicable forms.
- Coordination Model: check the appropriate box. Examples of Specialty/Centralized programs include Palliative Care Program, Respiratory Program, Stroke Program, PRIME, etc.
- Name of Case Coordinator: **print** first and last name of Case Coordinator.
- Office Location: office address of Case Coordinator (e.g. 2-975 Henderson).
- Phone: provide phone number of Case Coordinator.
- Fax: provide fax number of Case Coordinator.
- Name of Nursing Resource Coordinator: **print** first and last name of Nursing Resource Coordinator.
- Office Location: geographic area office address of Nursing Resource Coordinator (e.g. 2-975 Henderson).
- Phone: provide phone number of Nursing Resource Coordinator.
- Fax: provide fax number of Nursing Resource Coordinator.
- Height (feet/inches or centimetres): list height of client and circle the measurement used.
- Weight (pounds or kilograms): list weight of client and circle the measurement used.
- Current Medical Diagnoses: list all the current medical diagnoses that indicate the need for the Therapeutic Sleep Surface.
- Reason for Therapeutic Sleep Surface: check all boxes that apply. If the reason is for pressure ulcer treatment, check the appropriate box to indicate the stage of the ulcer.

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- Client is Currently: check appropriate box.
- Hospital Bed in Use: check appropriate box.
- Anticipated Length of Need for Therapeutic Sleep Surface: indicate how long Therapeutic Sleep Surface is required (e.g., client has end stage lung cancer, with prognosis of less than 1 month).
- Present Home Care Services: summarize the services that the client receives from Home Care.
- Mobility Level/Transfers: describe client's mobility level and how they complete transfers, and identify what transfer equipment client is using.
- Form completed by: signature, printed name and designation of person completing form, including the date the request was submitted.
- To be completed by Program Consultant:
 - Disposition: check appropriate box.
 - Type of Mattress: write in the type of equipment authorized and check mark if Dri Flo pads will be needed.
 - Printed name: printed name of Program Consultant.
 - Signature: signature of Program Consultant.
 - Date: date that the request was signed.

FILING/ROUTING INSTRUCTIONS

- If the client is coordinated by Community or Specialty/Centralized Home Care, the form is placed in the Home Care Client Office File.
- If the client is coordinated by Nursing, the form is placed in the Home Care Nursing Office File.

PRINTING INSTRUCTIONS

- Printed from Insite, single sided, on white paper.

AUTHOR

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