

Packet for Travel and Hospital Admissions

During an Oley Conference, several consumers and clinicians put their heads together to brain storm a document that would be helpful for consumers when they travel or are admitted into the hospital. The resulting packet is meant to help consumers communicate their medical needs and history to hospital personnel, and can be especially important for emergency admissions at an unfamiliar institution. We recommend that all consumers fill out the relevant parts of the packet and carry it with them whenever they leave home. Consumers may need help from their physician and/or homecare company to complete certain sections. If your travels take you to foreign lands, we recommend you translate at least the letter(s) into the native language of the country you are travelling to. Two Web sites that offer free foreign language translation are: babelfish.com and www.freetranslation.com.

The packet includes

1. a suggested cover letter (pick and choose which points/bulleted statements you wish to convey)
2. a general overview of personal information/medical history
3. a page for HPN specific information
4. a page for HEN specific information

Recognizing that many consumers may want to personalize their document, and that all will need to update it regularly, we offer the Travel/Hospital Admissions Packet in Microsoft Word as well. You can download this from the Oley Web site or email Roslyn Dahl at DahlR@mail.amc.edu.

Any questions? Call Roslyn Dahl at (800) 776-OLEY. We thank everyone who helped put this together, especially Marcia Wise, RN, Barbara Lorenzen, RN, and Irmagail Gordon.

Sample Letter for Hospital Admissions

Name _____
Address _____
City, ST Zip _____

Date: _____

Dear Healthcare Provider,

I am a person who requires specialized nutritional support to sustain my life. My physician and I are providing the following information to familiarize you with my special needs.

(Pick which of the following statements you wish to include in your letter.)

- I have a central venous catheter and/or enteral feeding tube. Maintaining access is critical to my ability to receive my nutrition.
- My physician and I have determined an appropriate regimen for the care of my catheter/tube. This protocol may be different than your standard protocol, but I would appreciate your following the recommendations in this form while I am in your institution, if at all possible.
- If I am able, I would prefer to take care of my own catheter.
- The following person has also been trained to care for my catheter and deliver my nutritional support:

Name: _____

Phone: (_____) _____ — _____

Please feel free to contact my physician for any questions you may have regarding my care.

Sincerely,

Consumer Signature

Consumer Name _____

Physician Signature

Physician Name: _____

Physician Phone #: (_____) _____ - _____

Sample Travel Letter for HPN (IV-fed) Consumers

Name
Address
City, ST Zip

Date:

To Whom It May Concern:

My patient, _____patient name_____, requires specialized nutrition support to sustain ___his/her___ life. ___He/She___ has a central venous catheter placed in ___his/her___ chest/neck/arm/leg___ and sustains ___his/herself___ by pumping a nutritional formula through this catheter.

**** If you will need to infuse during the flight add:** Because of ___his/her___ medical condition, ___he/she___ will need to infuse fluids through ___his/her___ catheter during the flight.

___He/She___ may be traveling with any combination of the supplies listed below:

- Feeding pump
- Intravenous (IV) formula
- Syringes
- Vials that contain vitamins and other additives/flushes
- Tubing, connectors, dressings, etc.

These supplies are medically necessary and will be difficult to obtain while ___he/she___ is away from ___his/her___ local physicians and suppliers; therefore I request that ___he/she___ be allowed to carry them with ___him/her___.

Please do not hesitate to contact me at (_____) _____ – _____ if you have any questions or need additional information.

Very sincerely,

____physician's name_____
____physician's title_____

Sample Travel Letter for HEN (Tube-fed) Consumers

Name
Address
City, ST Zip

Date:

To Whom It May Concern:

My patient, _____patient name_____, requires specialized nutrition support to sustain _____his/her____ life. ___He/She___ has an enteral feeding tube placed in ___his/her___ abdomen and sustains ___his/herself___ by pumping a nutritional formula through this tube.

**** If you will need to pump formula during the flight add:** Because of _____his/her___ medical condition, ___he/she___ will need to infuse formula through _____his/her___ tube during the flight.

___He/She___ may be traveling with any combination of the supplies listed below:

- Feeding pump
- Canned formula
- Syringes
- Tubing and feeding bags, etc.

These supplies are medically necessary and could be difficult to obtain while ___he/she___ is away from ___his/her___ local physicians and suppliers; therefore I request that ___he/she___ be allowed to carry them with ___him/her___.

Please do not hesitate to contact me at (_____) _____ – _____ if you have any questions or need additional information.

Very sincerely,

_____physician's name_____

_____physician's title_____

All Consumers

1. Personal Information

Patient Name: _____
 Caregiver Name: _____
 Relationship to patient: _____
 Address: _____
 Phone #: (_____) _____ — _____
 Insurance Provider: _____
 Policy or ID #: _____
 Group #: _____

Emergency Contacts:

Name: _____
 Phone #: (_____) _____ — _____
 Name: _____
 Phone #: (_____) _____ — _____

2. Clinician Contacts

Primary Physician: _____
 Address: _____
 Phone #: (_____) _____ — _____

Physician Managing HomePEN: _____
 Address: _____
 Phone #: (_____) _____ — _____

Other Specialist: _____
 Area of Specialty _____
 Address: _____
 Phone #: (_____) _____ — _____

Homecare Agency: _____
 Address: _____
 Phone #: (_____) _____ — _____
 Homecare RN Name: _____

3. Medical History

(See attached *Discharge Summary* if available)

Primary Diagnosis: _____
 Other Diagnoses: _____

Type of HomePEN Therapy: ____ PN ____ EN ____ Both (check one)

Allergies: _____

Procedures/Surgeries: (See attached list of *Procedures* if necessary)

Date: _____ Procedure: _____
 Date: _____ Procedure: _____
 Date: _____ Procedure: _____
 Date: _____ Procedure: _____
 Date: _____ Procedure: _____
 Date: _____ Procedure: _____

Current Medications: (See attached list of *Medications* if necessary)

Medication	Strength	Dose	Frequency	Route (IV, tube, mouth)

Note: several medications come in different strengths, including heparin which comes in 10 unit, 100 unit, and 1000 unit strengths. The strength might be 5mg/5cc or 15mg/ml whereas the dose might be 5.0 cc or 10.0 cc

HPN (IV-fed) Consumers Only

4. Nutrition Related Information

Infusion Schedule:

I have been on the attached formula since ____/____.

(Attach a label from your bag.)

Infusion Vol.: _____ Rate: _____ Over _____ # hrs.

I infuse _____ #days/week

Time: (check one)

____ Overnight ____ Daytime ____ Around the Clock

Additives: (i.e. MVI, Iron, and Meds...list may be attached)

The following substances are added to my HPN:

Additive	Amount	Freq.

I infuse lipids ____ Yes ____ No (check one)

If yes, as a: ____ 3-in-1 Solution ____ Separate Sol. (chk one)

I infuse extra hydration (Attach label from bag):

____ Yes ____ No

If yes: Volume: _____ Rate: _____

I use gloves and mask when hooking up:

____ Yes ____ No (check one)

Other Pertinent Information:

Recent Lab Values: (See attached Lab Results)

Daily Input/Output:

Usual Weight _____ (may be a range)

Input Volume: Output Volume:

Oral _____ Urine _____

IV _____ Ostomy _____

Tube _____ Other _____

Total _____ **Total** _____

5. Access Information/Protocols

Central Venous Catheter:

Type: (check one)

____ Externalized Catheter ____ Port ____ PICC

Brand Name: _____ Size: _____

Date Inserted: ____/____/____

Inserted at Institution: _____

By: ____ Surgeon ____ Vascular Radiologist

____ Nurse ____ Other _____

Phone #: (_____) _____ — _____

If multilumen:

____ Lumen is for TPN

____ Lumen is for _____ (blood draws, pain meds,)

Flushing Protocol:

Solution: (i.e. saline, heparin) _____

Amount: _____ Frequency: _____

I use gloves and mask when flushing:

____ Yes ____ No (check one)

Dressing Change Protocol:

Frequency: _____

Dressing Type: _____

Skin Prep Solution: _____

Catheter/Securement Method: (check one)

____ Subcutaneous Cuff ____ Tape

____ Sutures ____ None

I use gloves and mask when changing my dressing:

____ Yes ____ No (check one)

Cap Change Protocol:

Type: _____

Frequency: _____

I use gloves and mask when changing my cap:

____ Yes ____ No (check one)

6. Pump & Supplies

1. Brand: _____ Mfg: _____

Used for ____ PN ____ EN ____ Pain Meds (check one)

Pump Tubing Brand & Reorder #: _____

2. Brand: _____ Mfg: _____

Used for ____ PN ____ EN ____ Pain Meds (check one)

Pump Tubing Brand & Reorder #: _____

Attachment Tubing (for EN button) Brand & Reorder #: _____

7. Ostomy (Output) Supplies & Protocol

Type of Ostomy: (check one)

____ Jejunostomy ____ Ileostomy ____ Colostomy

Date Created: ____/____/____

Institution/Surgeon: _____

Phone #: (_____) _____ — _____

I use the following for my appliance:

Type of Pouch: _____

Type of Wafer: _____

Type of Skin Prep: _____

I change my dressing/pouch every _____ days.

I use gloves when changing my ostomy dressing:

____ Yes ____ No (check one)

HEN (Tube-fed) Consumers Only

4. Nutrition Related Information

Feeding Schedule:

I use the following brand of formula: _____
 (Attach a label from your can.)

Method: (check one) Bolus Gravity Pump

Infusion Vol.: _____ Rate: _____ Over _____ # hrs.

I have _____ # of feedings/day

Total Volume fed in 24 hours: _____

I tube feed _____ #days/week

Time: (check one)

Overnight Daytime Around the Clock

Additives: (i.e. Iron, and Meds...list may be attached)

The following substances are added to my HPN:

Additive	Amount	Freq.

I infuse extra hydration (Attach label from bag):

Yes No

If yes: Volume: _____ Rate: _____

by: Tube IV (check one)

Other Pertinent Information:

Recent Lab Values: (See attached Lab Results)

Daily Input/Output:

Usual Weight _____ (may be a range)

Input Volume: Output Volume:

Oral _____ Urine _____

IV _____ Ostomy _____

Tube _____ Other _____

Total _____ Total _____

5. Access Information/Protocols

Feeding Tube:

Type: (check one)

N/G N/J G-Tube

G-Button J-Tube G/J- Tube

Brand Name: _____ Size _____

Date Inserted ____/____/____

Inserted at Institution: _____

By: Surgeon Intervent'l Radiologist

Gastroenterologist Other _____

Phone #: (_____) _____ — _____

Flushing Protocol:

Solution: (i.e. water, saline) _____

Amount: _____

Frequency: _____

Dressing Change Protocol:

Frequency: _____

Dressing Type: _____

Skin Prep Solution: _____

EN Tube Securement Method: (check one)

Attachment Device Tape

Sutures None

I use gloves when changing my dressing: (check one)

Yes No

6. Pump & Supplies

1. Brand: _____ Mfg: _____

Used for PN EN Pain Meds (check one)

Pump Tubing Brand & Reorder #: _____

Attachment Tubing (for EN button) Brand & Reorder #: _____

2. Brand: _____ Mfg: _____

Used for PN EN Pain Meds (check one)

Pump Tubing Brand & Reorder #: _____

Attachment Tubing (for EN button) Brand & Reorder #: _____

7. Ostomy (Output) Supplies & Protocol

Type of Ostomy: (check one)

Jejunostomy Ileostomy Colostomy

Date Created: ____/____/____

Institution/Surgeon: _____

Phone #: (_____) _____ — _____

I use the following for my appliance:

Type of Pouch: _____

Type of Wafer: _____

Type of Skin Prep: _____

I change my dressing/pouch every _____ days.

I use gloves when changing my ostomy dressing:

Yes No (check one)

KEEP ME SAFE

S

crupulous hand washing between patients and before procedures.

A

ssess and organize operations separating clean procedures from things like opening packages. Once you apply your gloves don't touch packages or other dirty items, think first.

F

riktion to the hub! Always scrub access points with alcohol or tincture of iodine prior to injecting medications, flushing solutions or connections.

E

stablish and maintain sterile to sterile fluid pathway. Only touch sterile pieces to sterile pieces.

KEEP ME FREE OF INFECTION

I have a lot of living to do!

Patients have been taught these basic principles and deserve this level of care.

Endorsed by:



(800) 776-6539 - www.oley.org

