Alberta Health Services

Long Term Care (LTC) Consult Request

Integrated Supportive & Facility Living (ISFL)

The ISFL LTC Consultants group is a multidisciplinary service team of health professionals managing clients in ISFL. The team includes: SLP, Skin & Wound, RRT, NP's & CNS.

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐Last ☐First		DOB*(dd-Mon-yyyy)*
PHN	ULI ☐Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X)		

Send completed form via fax or e-mail

Fax Number: 403.776.3850

Email: ISFL.LTCConsultants@albertahealthservices.ca

Urgency of consult

Consultation occurs between Monday to Friday between the hours of 8:00 AM to 4:15 PM. Priority maybe changed based on assessment.

☐ **Low** ☐ **Medium** ☐ **High**

Facility Name	Street Address	
Room Number Name or number of site unit	City	Postal Code

Patient Information

Goals Of Consultation	Consultant safety *(Specify any client/family behaviors OR Infectious diseases)*	
Current Active Diagnosis	Comorbidities	
Specialists Involved *(related to consult)*	Client currently in Hospital ☐ Yes ☐ No If yes which one _____	
Additional Client History *(attach if needed)*	Goals Of Care Designation *(confirmed by order/green sleeve)*	GOC Effective Date *(dd-Mon-yyyy)*
Height *(cm)* / Weight *(kg)*	☐ Bariatric *(greater than 125kg)* ☐ History of tobacco use	☐ Oxygen Dependent _____ L/MIN ☐ Current tobacco use

Primary Physician Full Name _____ Contact number _____	Alternate Decision Maker/Designate Name _____ Contact Number _____ Will they attend the consult visit? _____
Consult Awareness*(Are they aware and agreeable?)* Client/Designate ☐ Yes ☐ No Physician ☐ Yes ☐ No Site designate ☐ Yes ☐ No	

For On-Site Consult Arrangements

Site Contact Name	Site Contact Number	Site Contact E-mail
Site on Outbreak ☐ Yes ☐ No	Resident on an Outbreak unit ☐ Yes ☐ No	

Skin & Wound Nurse Consult *(Reason For Consult: (X) All That Apply)*

Wound ☐ Chronic ☐ Acute ☐ Surgical ☐ Skin Tear ☐ Hospital Acquired pressure ulcer **Etiology** Location of wound _____ BWAT Score _____ BRADEN or PURS Score _____	**Signs and symptoms of infection** ☐ Odor ☐ Increased exudate ☐ Pain ☐ Cellulitis ☐ Redness **Skin condition** ☐ Chronic ☐ Acute Location of skin Condition _____	**Lower leg assessment** ☐ Edema management ☐ Heal ability ☐ Edema ☐ Pitting ☐ Skin Breakdown **Ostomy** *(Colostomy/ileostomy/urostomy)* Type _____ Current Products _____ Reason for Ostomy _____

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Skin & Wound Nurse Consult *(continued)*

Request for pressure redistribution surface *(prs)* ☐ *Eligibility criteria reviewed *(see instruction sheet)*
BWAT score _____ date _____ Braden or PURS score ____ date _____

Pertinent Information

Respiratory Therapist Consult *(Reason For Consult: (X) All That Apply)*

☐ Respiratory assessment	☐ Oxygen therapy staff education	☐ Lung volume recruitment
☐ Artificial airway	☐ Tobacco cession	☐ Cough assist *(respirology order required)*
☐ Secretion clearing concerns	☐ CPAP education	☐ Other _____
☐ Respiratory medication education	☐ BPAP therapy	
☐ Dyspnea		

Pertinent Information

Speech Language Pathologist Consult *(Reason For Consult: (X) All That Apply)*

☐ Dysphagia *(E.G. Swallowing, feeding, eating, saliva, oral care)*	Current Feeding Status
☐ Communication *(talking, listening, voice, hearing, use of technology)*	☐ Oral *(specify texture)* _____
	☐ Feeding tube

Pertinent Information *(provide mealtimes and/or client's optimum time for appointment)*

Clinical Nurse Specialist *(Reason For Consult: (X) All That Apply)*

Staff education	*Assessment & recommendation for complex clients*
☐ Pleurex catheter	☐ Dementia
☐ Suprapubic, urethral catheters	☐ Enteral Nutrition Therapy
☐ Tenckhoff catheter	☐ Gastrointestinal/Genitourinary
☐ Biliary drain	☐ Respiratory/Cardiac
☐ Central line/PICC line/IV Therapy	☐ Mental health
☐ G tubes/PEG tubes	☐ Musculoskeletal
☐ Nephrostomy tubes	☐ Neurological
☐ Depression/dementia/delirium ☐ behaviors	☐ Bowel & bladder incontinence
☐ Other *(specify)* _____	☐ Other *(specify)* _____

Pertinent Information

Nurse Practitioner *(pessary care only)*

Type of Pessary _____	Last Pelvic Floor Clinic appointment date _____
Duration of Pessary use _____	Suggested date for next follow up appointment _____
Vaginal Estrogen/Moisturizer Type _____	

Pertinent Information

Completed By

Last Name	First Name	Discipline	Date *(dd-Mon-yyyy)*