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. Several websites offer free foreign language translation.

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.

Any questions? Call the Oley Foundation office at (518) 262-5079. We thank everyone who helped put this together, especially Marcia Wise, RN, Barbara Lorenzen, RN, and Irmagail Gordon.

The Oley Foundation

Help along the way

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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)*