Kingston Health Sciences Centre

Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital | KGH Hôpital Général de Kingston General Hospital

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Home Parenteral Nutrition (hPN) (Adult) – Referral

Please complete Section A and B and fax, with additional information as per Section C, to Attn: KHSC hPN Program fax number 613-544-3114

Section A: Admission Criteria and Information

Referral Date (YYYY/MM/DD)			
More Information Required (see Section C)	**Question**	**Yes**	**No**
	Is the patient medically and functionally stable and their need for parenteral nutrition is the only requirement keeping them in hospital?		
✓	Has the patient failed, or has a clear contraindication, to all forms of oral and/or enteral routes for nutrition?		
✓	Is the patient currently receiving enteral nutrition (EN)?		
✓	Is the patient currently receiving parenteral nutrition (PN)?		
	Will the patient be expected to receive parenteral nutrition greater than 3 months?		
	Does the patient have a history of line related sepsis?		
	Does the patient have a history of line thrombosis?		
	Does the patient have a history of liver related issues? (explain)		
✓	Has the patient been assessed by a Registered Dietitian (RD)? RD Name: RD Contact Number:		
	Does the patient agree to have regular hPN follow-up appointments (as frequent as monthly as required) and regular bloodwork at their local blood collection agency (as frequent as weekly as required)?*		
	Is the patient/caregiver willing, motivated, as well as, physically and cognitively able to safely manage their hPN care in the community, such as aseptic technique in care of their central venous access and hPN solution preparation, storage and administration?		
	Is the patient/caregiver free of compliance issues that jeopardize safe administration of hPN?		
✓	Is the patient taking parenteral anti-emetics or narcotics?		
	Does the patient have a terminal illness but expected to live a minimum of 3 months of good quality of life? If yes, describe prognosis and goals of care.		

* Patient may be expected to pay for some components of their yearly bloodwork.

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Section B: hPN (Adult) - Referral Form

Referring Physician or Nurse Practitioner:	Contact Number:
Referring Physician or Nurse Practitioner License Number:	
Primary Care Physician:	Contact Number:
Referring Unit/Institution:	
Primary Diagnosis:	
Relevant Medical/Surgical History:	
Patient's current location: □ Hospital □ Home Institution name: Unit/Room: Phone: Fax:	
Predicted Discharge Date: (YYYY/MM/DD)	
Adverse Reactions:	
Height: (cm)	Weight: (kg)
Type of Central Venous Access: □ PICC □ Hickman □ Port-a-cath □ Other:_____	
□ Single Lumen □ Double Lumen □ Triple Lumen	
Date of Central Venous Access insertion: (YYYY/MM/DD)	
Additional Information:	

Printed Name | Designation | Signature | Date (YYYY/MM/DD) | Time (HHMM)

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Section C: hPN (Adult) - Referral Checklist

Before faxing package include all relevant information as per the checklist below:

- ❑ Complete Sections A and B
- ❑ Reason for oral/enteral route failure and summary of the attempts to optimize oral and enteral routes of feeding
- ❑ Copy of current PN prescription
- ❑ Copy of current EN order (if applicable)
- ❑ Copy of RD's assessment and care plan
- ❑ Medication List with type, dosage, route and delivery
- ❑ Recent lab work trend (for the last week)
- ❑ Copy of documentation that confirms central venous access device tip location (e.g. central line insertion report, chest x-ray…etc.)
- ❑ Relevant medical history reports related to gastrointestinal (GI) or metabolic complications such as Small Bowel Follow Through, abdominal ultrasound, endoscopies, upper GI test, fecal fat test, and relevant surgical or procedural reports such as operative notes detailing length/portion of bowel resected, length of remaining bowel, health of remaining bowel…etc.

Please note: Once an inpatient has been assessed and accepted into the hPN program, it may take up to three weeks to complete the discharge process.