

# 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](http://babelfish.com) and [www.freetranslation.com](http://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](mailto: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

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*I have a lot of living to do!*

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

*Endorsed by:*



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