Packet for Travel and Hospital Admissions

This packet is designed to help consumers communicate their medical needs when they travel or are admitted into the hospital, and can be especially important for an emergency admission at an unfamiliar institution. We recommend that consumers carry the completed packet with them whenever they leave home. Consumers may need help from their physician and/or homecare company to complete certain sections. The packet can be downloaded as a pdf, or a MicroSoft Word document, from www.oley.org/TravelHospitalPacket.

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. Google and other 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 and your medical history
3. a page for HPN (IV nutrition) specific information
4. a page for HEN (tube feeding) specific information

More tips for traveling with home IV or tube-fed nutrition, including information on minimizing complications when getting through airport security, are posted at www.oley.org/TravelTipsHomePEN.

Any questions? Call the Oley Foundation office at (518) 262-5079.

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/tube.

• The following person has also been trained to care for my catheter/tube 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    Physician Signature

Consumer Name ___________________ 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 their life. They have a central venous catheter placed in their ___chest/neck/arm/leg___ and sustain themselves by pumping a nutritional formula through this catheter.

** If you will need to infuse during the flight add: ** Because of their medical condition, they will need to infuse fluids through their catheter during the flight.

They may be traveling with any combination of the supplies listed below:

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

These supplies are medically necessary and will be difficult to obtain while they are away from their local physicians and suppliers; therefore I request that they be allowed to carry them onboard.

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_____


To Whom It May Concern:

My patient, _________patient name______, requires specialized nutrition support to sustain their life. They have an enteral feeding tube placed in their abdomen and sustain themselves by pumping a nutritional formula through this tube.

** If you will need to pump formula during the flight add:  Because of their medical condition, they will need to infuse formula through their tube during the flight.

They may be traveling with any combination of the supplies listed below:

- Feeding pump
- Formula
- Syringes
- Tubing and feeding bags, etc.

These supplies are medically necessary and could be difficult to obtain while they are away from their local physicians and suppliers; therefore I request that they be allowed to carry them onboard.

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_____


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: __________________________________
Current Medications: (See attached list of Medications if necessary)
<table>
<thead>
<tr>
<th>Medication</th>
<th>Strength</th>
<th>Dose</th>
<th>Frequency</th>
<th>Route (IV, tube, mouth)</th>
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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.
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:

<table>
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<th>Additive</th>
<th>Amount</th>
<th>Freq.</th>
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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 ____ hydration ____ Meds (check one)
Pump Tubing Brand & Reorder #:

2. Brand: _______________ Mfg: _______________
   Used for ____ PN ____ hydration ____ Meds (check one)
Pump Tubing 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)
4. Nutrition Related Information

Feeding Schedule:
I use the following brand of formula: ________________
(Attach a label from your can/carton.)
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 _____ #s/week
Time: (check one)
     _____ Overnight _____ Daytime _____ Around the Clock

Other Pertinent Information:
Recent Lab Values: (See attached Lab Results)

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 #: (________) _________ — _________

Flush Protocols:
Solution: (i.e. water, saline) _______________________
Amount: ________________________________
Frequency: ________________________________

Dressing Change Protocols:
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. EN Pump & Supplies

1. Brand: ________________ Mfg: ________________
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)