**Children’s Community Nursing Team – Tracheostomy Referral Form**

**Please complete all boxes thoroughly failure to do so will result in non-acceptance of referral.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient Information** | | | | | |
| Name |  | | | | |
| Date of Birth |  | | | NHS Number |  |
| Address and Postcode |  | | | | |
| Ethnicity/ Religion |  | | | Gender |  |
| Telephone Numbers |  | | | | |
| Main Carer and Relationship to Child |  | | | Name of Alternative Carer |  |
| GP Name |  | | | GP Telephone |  |
| Health Visitor/ School Nurse Name |  | | | Social Worker Name |  |
| Safeguarding Concerns |  | | | | |
| Consultant Responsible for Care |  | | | Gateshead Consultant Involved |  |
| **Patient History and Nursing Intervention’s Required** | | | | | |
| **Specific Parameters for Observations:**  O2 Requirement: O2 Saturations:  Heart Rate: Respiratory Rate:  Blood Pressure: Capillary Refill:  Recession/ Work of breathing: | | | **How often is Tracheostomy tube being changed and suctioned:** | | |
| **Specific Concerns:** | | | **When to seek further support or return to hospital:** | | |
| **Equipment Required and Stock Codes:** Without these the patient cannot be discharged home and must be discharged with at least one weeks supply of all equipment. | | | | | |
| **Equipment** | | **Manufacturer, Size and Stock Code** | | | |
| Tracheostomy Tube | |  | | | |
| Emergency Tracheostomy tube | |  | | | |
| Tracheostomy Tube Ties | |  | | | |
| Suction Catheters | |  | | | |
| Swedish Nose | |  | | | |
| Tracheostomy Bibs or dressings | |  | | | |
| Ventilator Wet Circuits | |  | | | |
| Ventilator Dry Circuits | |  | | | |
| Any Extra Ventilator Circuits | |  | | | |
| Any other equipment required | |  | | | |
| Source of Referral (Name and Telephone Number): | | | | | |
| This referral should be discussed over the telephone with a member of the Children’s Community Nursing Team then **emailed** to the Children’s Community Nursing Team at[**ghnt.referrals-gatesheadccnt@nhs.net**](mailto:ghnt.referrals-gatesheadccnt@nhs.net) who will contact you to inform you whether the referral can be accepted. | | | | | |

**CCNT Use only**

**Checklist for Discharge**

|  |  |  |  |
| --- | --- | --- | --- |
| **Task** | **Date Completed and information** | **Nurse** | **Signature** |
| Order Pulse Oximeter |  |  |  |
| Provide family with Pulse Oximeter and explain use |  |  |  |
| Parameters set on Pulse Oximeter |  |  |  |
| Order 2 x suction machines |  |  |  |
| Provide family with suction machines and explain use |  |  |  |
| Order equipment as per referral form |  |  |  |
| Order any prescribed items as per referral form |  |  |  |
| Attend Discharge Planning meeting |  |  |  |
| Referred for addition support |  |  |  |
| Professional handover Newcastle-Gateshead |  |  |  |
| Details of who has been trained |  |  |  |
| Provided Family with CCNT contact details and working hours |  |  |  |