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

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

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| --- |
| **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 gan-tr.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 |  |  |  |