



COMMUNITY HOSPITAL DISCHARGE ORDER FORM FOR TRACHEOSTOMY PATIENT

1. Please provide the following information for Equipment Issuance prior to discharge:

- **Patient Information:**
 - Name: _____ Last Four Of SS#: _____
 - DOB: _____
 - Room#: _____
 - Anticipated Date Of Discharge: _____
 - Emergency Contact: _____
 - Phone #: _____
- **Facility name and phone number of the person making the referral:**
 - Hospital: _____ Contact Person: _____
 - Phone: _____ Ext.: _____

2. Airway Information:

- Tracheostomy Size: _____ Cuffed Uncuffed
 Fenestrated Unfenestrated
- Model (Brand/ i.e. Shiley XLT): _____

3. Does patient require supplemental oxygen? Yes _____ No _____

➤ **If "YES" Please fill out NON-VA Hospital Discharge Form for Oxygen**

4. Does patient require humidification? Yes No If "YES" Please select equipment:

- Air Compressor
- Large Volume Nebulizer
- Corrugated Tubing
- Tracheostomy Mask
- Y connectors
- Trach Collars

5. Supplies needed for discharge home (Check all that apply):

- Suction Machine:
- Yankauer with Suction Tubing:
- Suction Catheters: 10fr 14fr 16fr Other (Please Specify): _____
- Tracheostomy Kit:
- Tracheostomy Dressing (Drain Sponge):
- Inner Cannulas: SZ: _____ Brand: _____
- Fenestrated Unfenestrated

Disposable: Yes: Issue Inner Cannulas
 No: Replacement as needed

- Hydrogen Peroxide
- Sterile Water:
- Gloves: SZ: SM MED LG XLG
- Tracheostomy Ties
- Extra Tracheostomy Replacement:
 - Current Size: _____ _____ Cuffed Uncuffed
 - Fenestrated Unfenestrated
 - Next Size Smaller: _____ Cuffed Uncuffed
 - Fenestrated Unfenestrated

VA COMMUNITY HEALTH NURSING PROGRAM :LOCATION & INFO

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Link to CHN Resource Page: <https://www.va.gov/orlando-health-care/programs/>

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