LARY-PASS®

PERSONAL LARYNGECTOMY PASSPORT

This passport belongs to:

Name: _____

Address: _____

_____

Tel: _____

Hospital _____

Dept: _____

If you find this please return to the above address

THIS PASSPORT CONTAINS IMPORTANT INFORMATION ABOUT ME AND MY LARYNGECTOMY SURGERY. PLEASE READ THIS IF YOU ARE INVOLVED IN MY CARE.

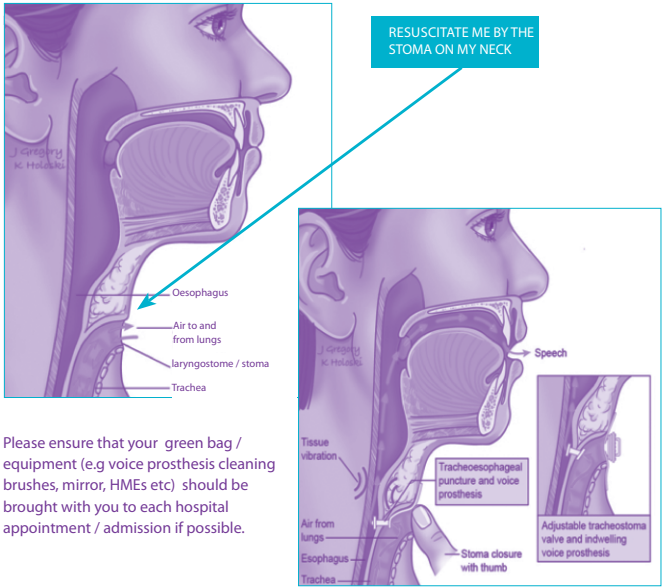
IMPORTANT

I am a neck breather. I have had Laryngectomy Surgery. This means that I no longer breathe through my nose or mouth. I breathe through a stoma in my neck.

If I need oxygen or resuscitation do not administer this through my mouth or nose. Administer to my stoma. Please check for and remove any mucous plugs in my stoma.

I may have a small one-way valve which sits in my stoma between my trachea and oesophagus. This enables me to produce voice and is sometimes also referred to as a voice prosthesis. Please do not remove this.

Contact my Ear Nose and Throat team (contact details opposite) for information after resuscitation or emergency intervention.



Please ensure that your green bag / equipment (e.g voice prosthesis cleaning brushes, mirror, HMEs etc) should be brought with you to each hospital appointment / admission if possible.

GENERAL COMMUNICATION INFORMATION

(tick all that are relevant)

I use:

- ☐ **a valve prosthesis** — Date of first valve fit:_____
  - ☐ with hands-free system
  - ☐ without hands-free system
- ☐ **an electrolarynx** — Type: _____ Date of issue: _____
- ☐ **oesophageal voice**
- ☐ **Text to speech on mobile telephone**
- ☐ **Writing**
- ☐ **Mouthing**
- ☐ **Communication chart**
- ☐ **Other** (e.g. writing / other communication aid etc)_____

_____

VOICE PROSTHESIS / VALVE

For current valve information please refer to page 7

Make:

☐ Indwelling ☐ Ex-dwelling

Changed by: ☐ Self ☐ Clinician

Relevant Information about Valve changes e.g. requires topical anaesthesia, extended time of dilatation, usual frequency, use of antifungal medications:

_____

_____

_____

_____

_____

ESSENTIAL HOSPITAL CONTACTS

Usual Hospital: _____

NAME & POSITION	CONTACT NUMBER
Consultant Ear Nose and Throat Surgeon:	
Speech and Language Therapist:	
Clinical Nurse Specialist:	
Dietitian:	
Consultant Oncologist:	
Consultant Radiotherapist:	
Other:	

ESSENTIAL COMMUNITY CONTACTS

NAME & POSITION	CONTACT NUMBER
GP	
Speech and Language Therapist:	
Clinical Nurse Specialist:	
District Nurse:	
Dietitian:	
Other:	

Next of kin: _____

Name: _____

Telephone: _____

MEDICAL INFORMATION

Date of Laryngectomy: _____

Place of surgery: _____

Description of surgery:

- ☐ total laryngectomy
- ☐ extended laryngectomy
- ☐ reconstruction

Further informnation: _____

Date completed radiotherapy (if appropriate): _____

Date completed chemotherapy (if appropriate): _____

Medication: _____

STOMA CARE

stoma patency device: ☐ Yes ☐ No

☐ Laryngectomy Tube ☐ Stoma Stud ☐ Baseplate

Other: (please state): _____

Size: _____

Stoma Cover: ☐ Yes ☐ No

☐ Laryngofoam ☐ Bibs ☐ Baseplate

Other: (please state): _____

Size: _____

Stoma Hygiene Routine:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

HEAT MOISTURE EXCHANGE SYSTEM (HME):

☐ Yes ☐ No Type: _____

Baseplate:

Adhesives: ☐ Yes ☐ No Type: _____

Skin Preparation: ☐ Yes ☐ No Type: _____

Adhesive Remover: ☐ Yes ☐ No Type: _____

Other: _____

SWALLOWING

Swallowing Assessment Date: _____

Results: _____

_____

Swallowing function: _____

_____

Swallowing recommendations: _____

_____ Date: _____

Fluids:

Free	
Stage 1	
Stage 2	
Stage 3	

Solids:

No Alteration	
Soft	
B = Thin Purée Dysphagia Diet	
C = Thick Purée	
D = Pre-mashed	
E = Fork Mashable	

RIG	
PEG	
NG	
NBM	
NJ	
Stoma Gastric	
Other	

HEAT MOISTURE EXCHANGE SYSTEM (HME):

☐ Yes ☐ No Type: _____

Baseplate:

Adhesives: ☐ Yes ☐ No Type: _____

Skin Preparation: ☐ Yes ☐ No Type: _____

Adhesive Remover: ☐ Yes ☐ No Type: _____

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PEG	
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Stoma Gastric	
Other	

VOICE PROSTHESIS/VALVE CARE RECORD

Date	D D / M M / Y Y
	(Attach valve information label here)
Routine:	☐ Yes ☐ No If No please detail: _____
Changed by:	Name: _____ Role: _____ Signature: _____
Replacement Valve:	☐ Indwelling ☐ Ex-dwelling Make: _____ Size: __Fr _____ Length _____ Comments about procedure: _____ Review in: _____ Weeks _____ Months Recommendations for next change: _____

VOICE PROSTHESIS/VALVE CARE RECORD

Date	D D / M M / Y Y
	(Attach valve information label here)
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KAPITEX®

Adding Quality of Life to
Airway Management

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