TRACHI-PASS®

PERSONAL TRACHEOSTOMY PASSPORT

This passport belongs to me. Please return it.

First Name: ______________________________

Surname: ______________________________

I HAVE UPPER AIRWAY PATENCY:

☐ **YES** ☐ **NO**

THIS PASSPORT CONTAINS IMPORTANT INFORMATION ABOUT YOU AND YOUR TRACHEOSTOMY. PLEASE TAKE IT WITH YOU TO ALL APPOINTMENTS.

PLEASE READ THIS IF YOU ARE INVOLVED IN MY TRACHEOSTOMY CARE

AFFIX HOSPITAL LABEL

Tel No: ______________ Mobile No: ______________

ESSENTIAL CONTACTS

HOSPITAL TRACHEOSTOMY: ______________

Name: ______________

Role: ______________

Tel No: ______________

COMMUNITY TRACHEOSTOMY: ______________

Name: ______________

Role: ______________

Tel No: ______________

GP: ______________

Surgery: ______________

Tel: ______________

NEXT OF KIN: ______________

Tel: ______________

Name: ______________ Signature: ______________ Date ______________

TRACHEOSTOMY / AIRWAY DETAIL

Date of Insertion: ______________

Size: ______________

Make: ______________

Percutaneous		Cuffed		Inner Tube		Fenestrated	
Surgical		Un-Cuffed		No Inner Tube		Un-Fenestrated	

Sub-Glottic Port: ☐ Yes ☐ No

Reason for insertion: ______________

Relevant PMH: ______________

____

Relevant DH: ______________

____

____

Tracheostomy RED FLAG Information:

Upper Airway: ☐ Patent ☐ Not Patent ☐ Difficult

Relevant detailed information: ((*eg. Bleeding, Granulation, Occlusion, Dislodged tube, false track.)*

____

____

____

____

____

____

____

Name: ______________ Signature: ______________ Date ______________

TRACHEOSTOMY TUBE MANAGEMENT

Inner Tube: ☐ YES ☐ NO

If YES by WHO: ____________________

Change: __________ x Daily

Clean: __________ x Daily

Cleaning Method: ____________________

____

____

Cuffed: ☐ YES ☐ NO

If YES detail of cuff management *(eg. hours on inflation or deflation):*

Day: ____________________

____

Night: ____________________

____

Cuff Pressure Checks

Frequency: ____________________

Equipment: ____________________

____

Target Pressure: __________ OR Volume: __________

Name: __________ Signature: __________ Date __________

Tracheostomy Tube Management:

Fenestrated: ☐ YES ☐ NO

If YES any relevant information (eg. used when): ____________________

____

Tube Securing Device: *(eg. Twill, Velcro Holder)*

Type: ____________________

Size: ____________________

Change: ____________________

Secretion Management:

Sub-Glottic Port ☐ YES ☐ NO

If YES detail of management (eg. how often suctioned):

Frequency: ____________________

Usual volume: ____________________

Equipment Used: ____________________

Tracheal Suction:

Frequency: ____________________

Catheter size: ____________________

Type: ☐ Closed ☐ Open

Carried out by: ____________________

Name: __________ Signature: __________ Date __________

Sputum: *(normal appearance and volume)*

____

____

Cough Ability:

Comment: ______________________________

Chest Clearance Routine: ☐ YES ☐ NO

If YES detail of management (eg. cough assist, physio techniques):

____

____

STOMA Management:

Tissue Viability Comment: ______________________________

____

Dressing: ______________________________

Barrier Protection: ______________________________

Stoma Site Cleaning Routine: ______________________________

____

Humidification:

TYPE	USAGE
Airway Protector eg Buchannan Bib	
Heated Humidifier eg Fisher & Paykel viaTrache Mask	
Swedish Nose Style HME	
Nebulisers	

Name: ______________ Signature: ______________ Date ______________

Communication:

Speaking Valve	
Occlusion Cap	
Written	
Light Writer	
Other	

Speaking Valve:

Type: ______________________________

Management Details *(eg. day/night, duration):* ______________________________

____

Communication:

Swallowing Assessment Date: ______________________________

Results: ______________________________

____

Fluids:

Free	
Stage 1	
Stage 2	
Stage 3	

Solids:

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

RIG	
PEG	
NG	
NBM	
NJ	

Name: ______________ Signature: ______________ Date ______________

TRACHEOSTOMY CARE RECORD

Date	DD / MM / YY
	(Attach Tube Lot Label here or Note Relevant Care Details)
Routine:	☐ Yes ☐ No If No please detail: ______
Changed by:	Name: ______ Role: ______ Signature: ______

Date	DD / MM / YY
	(Attach Tube Lot Label here or Note Relevant Care Details)
Routine:	☐ Yes ☐ No If No please detail: ______
Changed by:	Name: ______ Role: ______ Signature: ______

TRACHEOSTOMY CARE RECORD

Date	DD / MM / YY
	(Attach Tube Lot Label here or Note Relevant Care Details)
Routine:	☐ Yes ☐ No If No please detail: ______
Changed by:	Name: ______ Role: ______ Signature: ______

Date	DD / MM / YY
	(Attach Tube Lot Label here or Note Relevant Care Details)
Routine:	☐ Yes ☐ No If No please detail: ______
Changed by:	Name: ______ Role: ______ Signature: ______

TRACHEOSTOMY CARE RECORD

Date	D D / M M / Y Y
	(Attach Tube Lot Label here or Note Relevant Care Details)
Routine:	☐ Yes ☐ No If No please detail: ____________
Changed by:	Name: ____________ Role: ____________ Signature: ____________

Date	D D / M M / Y Y
	(Attach Tube Lot Label here or Note Relevant Care Details)
Routine:	☐ Yes ☐ No If No please detail: ____________
Changed by:	Name: ____________ Role: ____________ Signature: ____________

TRACHEOSTOMY CARE RECORD

Date	D D / M M / Y Y
	(Attach Tube Lot Label here or Note Relevant Care Details)
Routine:	☐ Yes ☐ No If No please detail: ____________
Changed by:	Name: ____________ Role: ____________ Signature: ____________

Date	D D / M M / Y Y
	(Attach Tube Lot Label here or Note Relevant Care Details)
Routine:	☐ Yes ☐ No If No please detail: ____________
Changed by:	Name: ____________ Role: ____________ Signature: ____________

FREE TRACHI-PAC

Please send me a complimentary ***TRACHI-PAC***. Trachi-Pac contains useful tracheostomy information, including a range of sample products available on prescription from Kapitex Healthcare.

Name: ____

Address: ______________________________________

____

Postcode _______________ Tel No: __________________

Email Address: __________________________________

I agree that my name can be added to your database so that I can be updated on new products. Any personal information you give to us will be processed in accordance with the UK Data Protection Act 1998. Kapitex will use the information to process your request and to provide any further relevant information.

TEAR ALONG PERFORATION, FOLD OVER & SEAL. ALTERNATIVELY PLACE IN AN ENVELOPE AND SEND TO THE FREEPOST ADDRESS OVERLEAF.

Kapitex Healthcare Ltd
FREEPOST LS2604
Unit 1, Erivan Park
Sandbeck Way
Wetherby
West Yorkshire
LS22 7DN

KAPITEX®

Adding Quality of Life to
Airway Management

Kapitex Healthcare Ltd,
Unit 1, Erivan Park, Sandbeck Way,
Wetherby, West Yorkshire LS22 7DN, UK
Tel: 01937 580211 • Fax: 01937 580796
Email: sales@kapitex.com

www.kapitex.com

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