

TRACH SETUP WORKSHEET

PATIENT NAME: _____ DATE: _____ TIME: _____

LOCATION: _____ ROOM #: _____

Please Circle Trach Size Needed: (located on the neck of the trach)	CIRCLE WHAT IS NEEDED TRACH TYPE: SIZES: 4 6 8 10 CUFFED UNCUFFED FENISTRATED NON-FENISTRATED TRACH WATER O2 Percentage:
Other Equipment:	
(NOT LITER FLOW)	

PHYSICIANS ORDER (ATTACH COPY PLEASE) _____

ADDITIONAL INFORMATION: _____

DELIVERY DATE: _____

REQUESTED BY: _____	PHONE # _____	EXT: _____
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PLEASE COMPLETE THE FOLLOWING INFORMATION FOR THE TRACH SETUP.
UPON RETURN OF THE COMPLETED FORM THE TRACH SETUP WILL BE ISSUED.

OFFICE USE ONLY:

PAR: _____ DATE _____

SIGNATURE: _____