Alberta Health Services

Tracheostomy Clinic Referral

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown		

For more information on criteria and where to send the referral visit: http://www.albertareferraldirectory.ca

Discharge Date *(dd-Mon-yyyy)*	Discharged Site	General Practitioner Name
MRP *(ENT Physician)*	Pulmonary Diagnosis	

Relevant History *(Provide copy of Patient history, consults and discharge notes to Tracheostomy Clinic)*

Special Needs ☐ No ☐ Yes, please specify _____	Caregiver Name

Type of Current Tracheostomy device

☐ Shiley ☐ Portex ☐ Silver Jackson ☐ Other _____

☐ Cuffed ☐ Uncuffed ☐ Fenestrated ☐ Unfenestrated

Size ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ Other _____

Date of Initial Tracheostomy Procedure *(Surgery)* *(dd-Mon-yyyy)*	Hospital Site	Surgeon Name
Last Trach Tube Change performed *(dd-Mon-yyyy)*	Performed by ☐ RRT ☐ Physician *(specify name)* _____	

Respiratory Vendor Name	☐ Respiratory Vendor Notified	☐ Trach Tube/Equipment Orders Faxed to Respiratory Vendor

Referring RRT Name	Contact/Pager Number	☐ Community RRT Notified

The referring physician is allowing the Tracheostomy Clinic RRT to assess and care for the patients' Tracheostomy care as needed. The Tracheostomy Clinic is under direction of an Otolaryngologist.

Referring Physician Name	Signature	Date *(dd-Mon-yyyy)*