**DISCHARGE PLANNING ORDERS FOR RESPIRATORY HOME CARE OF THE ADULT PATIENT**  
(Adults 18 & older)

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**Diagnosis:** _______________  
**Tracheostomy (type/size):** _______________

**Current in-hospital weaning orders:** _________________________________________________________________

*Patient will be stable on consistent ventilator settings two weeks prior to discharge*

**Current respiratory support:** _______________________________________________________________________

**Physician to indicate each ordered teachings, equipment, and supplies:**

**Teaching by hospital staff prior to home caregivers 48 hour stay:**

1. Routine tracheostomy care  
2. Sterile suctioning technique  
3. Airway management with ambu bag  
4. Ventilator transport mode  
5. Other: __________________________________________________________________________________

**Teaching by medical equipment provider staff or home health nurse:**

1. CPR with trach tube  
2. Use and care of equipment at home  
3. Trach tube cleaning and suctioning at home  
4. Set up and maintenance of travel emergency bag  
5. Other: __________________________________________________________________________________

**Equipment needed:**

1. Portable suction machine  
2. Suction catheters:  size _______ quantity_______  
3. Tracheostomy tube(s):  type_____________________________ size _______ quantity_______  
   - disposable inner cannulas:  size _______ quantity_______  
   - humidivents (trach-vents):  quantity_______ normal saline vials:  quantity_______  
4. Trach holders:  Type_____________________________ quantity_______  
5. Trach cleaning kits:  quantity_______  
6. Oral suction catheter (i.e. Yankeur):  quantity_______  
7. Adult resuscitation (ambu) bag  
8. Backup "E" cylinder  
9. Oxygen concentrator/air compressor  
10. Passover type heated humidity device  
11. Travel/emergency bag  
12. Ventilator:  type_____________________________ Settings:  Rate_______ FiO2_______  
   - peep ______ tidal volume _______ pressure limit _______ other _______  
   - Alarms:  high pressure _______ low pressure _______ other _______  
13. Trach collar Fio2:  _______  
14. Aerosol/MDI/Other Therapies:  

**M.D. Signature:** _________________________  
**MD ID No:** _______________  
**Pager:** __________  **Date:** __________

**APRN/RT Signature:** _________________________  
**Pager:** __________  **Date:** __________

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Fax to: _________________________  
From: _________________________  
Date/Time ____________

Unapproved abbreviations – U, IU, OD, QOD, MS, MSO4, MgSO4, doses without leading zeros, doses with trailing zeros, AU, AD, AS, AL, OS, OD, OU, ug.