



True Friends
10509 108th St NW
Annandale, MN 55302
Tel: 952.852.0101
registration@truefriends.org
www.truefriends.org

Session _____

Cabin _____

Cabin Copy _____

Nurse Copy _____

Suctioning/ Tracheostomy Questionnaire

Suctioning

Type: Oral Nasal

Equipment used: Catheter, size _____ Yankers

How often is suctioning scheduled?: _____

If suctioning is not scheduled, what are indications that suctioning is needed?: _____

Steps on how to suction your participant: (position, supplies, cleaning technique)

1. _____
2. _____
3. _____
4. _____

Tracheostomy

Type: _____ Size: _____ Cuffed Uncuffed

"Emergency trach changes will only be administered by a licensed health care professional"?

Participant's Protocol for Emergency Trach Change: _____

Steps on Trach care and (position, supplies, cleaning technique)

1. _____
2. _____
3. _____
4. _____

Additional helpful information:

Name of Person Completing Form

Relationship to Participant

Phone

Date