BlueCare Tennessee

Enhanced Respiratory Care
Ventilator Weaning and Sub-Acute Tracheal Suctioning Request

Fax: (423) 591-9398

Request Date:	
Request Type: ☐ **Ventilator Weaning** ☐ **Sub-Acute Tracheal Suctioning**	
Member Information	
Member Name:	Date of Birth:
Member SSN:	Reference/Auth Number:
Member Current Phone:	
Nursing Facility Information	
Expected Dates of Service:	
Facility Name:	
Facility Contact:	
Facility Address:	
Facility City, State, Zip:	
Facility Phone:	Fax:
Provider Number/NPI:	Tax ID Number:
Prescribing Physician Information	
Prescribing Physician Name:	
Prescribing Physician Address:	
Prescribing Physician City, State, Zip:	
Prescribing Physician Phone:	Fax:
Provider Number/NPI:	Tax ID Number:
Admitting Physician Information	
Admitting Physician Name:	
Admitting Physician Address:	
Admitting Physician City, State, Zip:	
Admitting Physician Phone:	Fax:
Provider Number/NPI:	Tax ID Number:

Clinical Information		
Diagnosis:		
Height:	Weight:	
Ventilator Care Information		
Required Supporting Documentation:	☐ Signed physician orders ☐ Respiratory log	☐ History and Physical ☐ Nursing Progress Notes

Check all services that have been utilized during the dates of service requested:	
☐ RT to evaluate and treat	☐ Wean from ventilator as tolerated
☐ Weaning parameters performed every_____	☐ Titrate O_2
☐ T-piece or trach mask spontaneous breathing trials	☐ Trach suction every_____
☐ O_2 Saturation checks every______	☐ End Tidal CO_2 checks every______
☐ O_2 at______LPM or _____% via ☐ Trach ☐ Mask	☐ Vent
☐ Ventilator Orders: Mode_____Rate_______Vt_______PS_______PEEP_______O_2Flow_______	

Additional Comments:

Progress Toward Goals / Changes in Plan of Care / Discharge Plans:

Please fax the completed form to (423) 591-9398.