

Barcode



Community oxygen request form

Patient Label

Name: _____

NHI: _____ DOB: _____
dd/mm/yy

Address: _____

Date _____
dd/mm/yy

Adult clinical information (Please tick which applies)

<input type="checkbox"/> Chronic obstructive pulmonary disease (COPD)	<input type="checkbox"/> Pulmonary vascular disease	<input type="checkbox"/> Severe chronic asthma
<input type="checkbox"/> Interstitial lung disease	<input type="checkbox"/> Pulmonary malignancy	<input type="checkbox"/> Cystic fibrosis
<input type="checkbox"/> Palliative care (Pulmonary)	<input type="checkbox"/> Bronchiectasis (Not cystic fibrosis)	<input type="checkbox"/> Non pulmonary palliative care
<input type="checkbox"/> Chronic heart failure	<input type="checkbox"/> Other (please specify): _____	

Smoking status Current *Do not refer* Ex smoker (Date stopped) _____

Oximetry (SpO2) ON AIR	Arterial blood gases ON AIR
Date _____	Date _____
SpO2 _____	PaO2 _____ PaCO2 _____ pH _____ HCO3 _____ CarboxyHb _____

ON OXYGEN

Device (tick one) Nasal cannulae Venturi mask _____ %
Specify flow rate _____ L/min

Oximetry	Arterial blood gases
Date _____	Date _____
SpO2 _____	PaO2 _____ PaCO2 _____ pH _____ HCO3 _____ CarboxyHb _____

For PALLIATIVE referrals ONLY (Blood gases not usually indicated)

Patient has life expectancy of less than three months Yes No

Patient exhibits breathlessness on room air at rest Yes No

Alternative strategies for managing breathlessness have been tried (pharmacological and non pharmacological) Yes No

Patient has hypoxia secondary to respiratory malignancy and/or respiratory disease Yes No

Stable SpO2 after 15 minutes quietly seated on room air _____ %.

(If answer is NO to any questions above or SpO2 ≥ 92% please discuss with oncall respiratory physician).

Client location

Outpatient Inpatient Hospital _____ Ward _____

Requestor details

Name _____ Signature _____ Contact details _____

Fax to Respiratory on 07 839 8770 - if urgent discuss with respiratory physician

Equipment request (Authorised prescriber only to complete)

<input type="checkbox"/> Long term oxygen therapy: concentrator Device (tick one) <input type="checkbox"/> Nasal cannulae <input type="checkbox"/> Venturi mask _____ % Flow rate _____ L/min Hours / day _____	<input type="checkbox"/> Ambulatory: regulator Litres / minute: _____ Number of bottles: _____
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Prescription details (Respiratory physician only to complete)

Approved - Faxed to 07 839 3897 **Declined**

Name _____ MCNZ Reg _____

Signature _____ Date _____

Patient Label

Name: _____
NHI: _____ DOB: _____
Address: _____

or patient details

dd/mm/yy

Domiciliary oxygen request form (Key points)

Before considering oxygen therapy a patient must be smoke free for four weeks and remain smoke free. Oxygen therapy will be withdrawn if patient fails to comply.

Criteria for consideration for long term oxygen (LTOT) in chronic obstructive pulmonary disease (COPD)

- Stable day time PaO₂ ≤ 7.3 kPa at rest **or**
- Stable day time PaO₂ 7.4 - 7.8 kPa at rest with evidence of hypoxic organ damage (including right heart failure, polycythaemia or pulmonary hypertension).

Provision of oxygen for other reasons than outlined above or for palliative reasons must be discussed with the respiratory physician on call at Waikato Hospital.

Process

- Complete form and fax to **07 839 8770** for approval by respiratory physician.
- Respiratory physician will fax back, indicating approved or declined, to referrer within 24 hours.
- Approvals will include oxygen flow rate and equipment to be supplied.
- Rural hospital respiratory physician will fax form to **07 839 3897** - Community Equipment and Supply to request equipment.
- Waikato Hospital fax form to: _____

Delivery of equipment:

- **Waikato Hospital:** Daily by courier arriving at approximately 1400hrs, (providing requests are faxed by 1000hrs).
- **Rural hospitals:** Daily by courier, allow 24 hours for delivery.
- **Outpatients:** Couriered to patient's home, allow 24 hours for delivery.

Follow up

- Refer to district nurses for follow up and attach community oxygen request form.
- Refer to Respiratory Clinic for follow up with in two months of commencing oxygen therapy.

Reference:

http://www.thoracic.org.au/imagesDB/wysiwyg/OxygenGuidelines_March2014_FINAL1.pdf