



Domiciliary Oxygen Program

Department of Respiratory Medicine
Austin Health

Ph 03 9496 3669 FAX 03 9496 3723

Supplied in accordance with the guidelines of the
Thoracic Society of Australia and New Zealand.

INSTRUCTIONS: Please note that incomplete forms will be returned.

PAGE 1: Summary of indications for domiciliary oxygen

PAGE 2: Complete all sections (1-9)

PAGE 3: Complete section 15 PLUS Section 11 – Continuous
Section 12 – Nocturnal
Section 13 and 14 – Exertional *

* not routinely provided on discharge from hospital – refer to summary of indications

DOMICILIARY OXYGEN THERAPY – SUMMARY OF INDICATIONS

Detailed information can be found in the following documents (available on request) –

1. Adult Domiciliary Oxygen Therapy. Position statement of the Thoracic Society of Australia and New Zealand.
2. A+EP Guidelines for the Provision of Oxygen.
3. DVA Procedural Guidelines for Home Medical Oxygen Therapy.

1. CONTINUOUS

1. PaO₂ = 55 mmHg. ABG's must be taken at rest, after 20mins on room air, on optimal treatment, not during acute exacerbations or while clinically unstable.
 - OR 2. PaO₂ 56 – 59 mmHg With evidence of right heart failure, pulmonary hypertension or polycythaemia.
- Identify the O₂ flowrate which maintains PaO₂ > 60 mmHg (SpO₂ > 90%).

2. EXERTIONAL

Not routinely provided on discharge from hospital. Only provided in the following circumstances:

- Palliative patients (see below)
- Exceptional circumstances when approved by a respiratory consultant

In all other instances an oxygen assessment needs to be conducted once the patient is in a stable phase of the condition, at least 4 weeks post discharge from hospital. Please complete the domiciliary O₂ form and fax the form as a request for an outpatient oxygen clinic appointment.

Must demonstrate evidence of exercise induced oxygen desaturation on an exertional test to SpO₂ = 88% while breathing room air

PLUS a demonstrable improvement in exercise performance on supplemental O₂

PLUS the following additional information –

1. Minimum O₂ flowrate required to achieve improvement
2. Patient's mobility status

3. NOCTURNAL

Evidence of oxygen desaturation to SpO₂ = 88% based on continuous overnight SpO₂ monitoring during sleep. SpO₂ = 88% should occur for greater than ¹/₃ of the sleep time. Identify the O₂ flowrate that maintains SpO₂ > 90%.

4. EMERGENCY

Indicated in patients with severe asthma who are prone to sudden, life threatening episodes.

5. PALLIATIVE

Indicated in terminally ill patients with evidence of hypoxaemia (SpO₂ < 90%) and a life expectancy of less than three months. Oxygen use is for relief of symptoms.

RE-ASSESSMENT REQUIREMENTS

Clinical re-assessment is required for continuous and exertional set-ups occurring in the acute hospital setting. Reassessment must occur at least 4 weeks after initial assessment, when patient is in a stable phase of the condition to determine the ongoing oxygen requirements. Requirements as outlined above must be met for continuation of oxygen therapy at the 4 week review.

CONTRA-INDICATIONS

1. Dyspnoea in COPD with PaO₂ = 60mmHg.
2. Current tobacco smokers.
3. Patients who have not received adequate therapy of other kinds.
4. Patients who are not motivated to use oxygen therapy according to prescription.

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SECTION 1: PATIENT DETAILS

Surname: _____ First Name: _____ UR #: _____ DVA #: _____

DOB: ____/____/____ Sex: M / F Address: _____

Suburb: _____ PostCode: _____ Phone: _____

Next Of Kin:

Name: _____ Relationship: _____ Phone: _____

GP Details: Name: _____ Address: _____

Telephone: _____

Patient Location at Time of Request: Public Hosp Private Hosp Nursing Home Hostel Patient's Home

Hospital name and ward: _____ Contact phone number: _____

Discharge Date: ____/____/____

SECTION 2: DELIVERY ADDRESS

Patient's Home (as above)

Other (give details)

SECTION 3: THERAPY GROUP

Continuous Nocturnal Exertional

Palliative Emergency

If Palliative:

Has patient been referred to palliative care service Y / N

Is life expectancy < 3 months Y / N

SECTION 4: SMOKING HISTORY

Status: Never Average cigs/day: _____

Current

Ex

Years smoked: _____

Date ceased: ____/____/____

SECTION 5: DIAGNOSTIC GROUP (list details)

COPD Cardiac _____

DILD Cancer _____

Asthma Other _____

SECTION 6: MEDICAL EVIDENCE OF

Right Heart Failure Y / N

Polycythaemia Y / N

Pulmonary Hypertension Y / N

SECTION 7: MEDICATIONS

Bronchodilators _____ Inhaled steroids _____

Theophylline _____ Oral steroids _____

SECTION 8: Four Week Review Arrangements

Physician review for 4 weeks after commencing therapy has been planned with _____

at _____ on ____/____/____

SECTION 9: REQUESTED BY

Title: _____ Name: _____ Specialty: _____

Organization: _____ Address: _____

Suburb: _____ PostCode: _____ Phone: _____ Pager: _____

Signed: _____ Date: ____/____/____

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SECTION 11: ARTERIAL BLOOD GASES

Date: / /		
	Room Air	Supp O2
O ₂ Flow (L/min):		
pH:		
PaCO ₂ (mmHg):		
PaO ₂ (mmHg):		
SaO ₂ (%):		

SECTION 12: NOCTURNAL SaO₂ ASSESSMENT

Date: / /	
Awake baseline SpO ₂ (%):	
Minimum asleep SpO ₂ (%):	
% Sleep time SaO ₂ < 88%:	

SECTION 13: EXERTIONAL OXYGEN ASSESSMENT – 6 Minute walk test

Date: / /		Room Air	Supp O2
O ₂ Flow (L/min):			
Rest	SpO ₂ (%):		
	HR (bpm):		
	Borg Score:		
End exercise	SpO ₂ (%):		
	HR (bpm):		
	Borg Score:		
Distance (m):			
Recovery Time:			

SECTION 14: MOBILITY ASSESSMENT:

<input type="checkbox"/> Ambulant and independent
<input type="checkbox"/> Ambulant with mobility aid - <input type="checkbox"/> walking frame with basket <input type="checkbox"/> stick <input type="checkbox"/> crutches
<input type="checkbox"/> Non-ambulant – <input type="checkbox"/> wheelchair <input type="checkbox"/> scooter

SECTION 15: OXYGEN REQUIREMENTS

Tick options and specify O ₂ flowrate and usage	O ₂ FLOW (L/min)	USAGE (hrs/day)
OXYGEN CONCENTRATOR <input type="checkbox"/> Continuous <input type="checkbox"/> Palliative <input type="checkbox"/> Nocturnal		
PORTABLE OXYGEN (Complete section 13 & 14)	TYPE	CYLINDER
<input type="checkbox"/> Exertional	<input type="checkbox"/> Carry Bag	<input type="checkbox"/> 200 L
		<input type="checkbox"/> 400 L
<input type="checkbox"/> Palliative	<input type="checkbox"/> Trolley	<input type="checkbox"/> 400 L
		<input type="checkbox"/> 600 L
EMERGENCY <input type="checkbox"/> Asthma Kit: 1500 L Cylinder Kit		PRN