DOMICILIARY OXYGEN THERAPY – SUMMARY OF INDICATIONS

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

1. CONTINUOUS
   1. PaO$_2$ = 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. PaO$_2$ 56 – 59 mmHg With evidence of right heart failure, pulmonary hypertension or polycythaemia. Identify the O$_2$ flowrate which maintains PaO$_2$ > 60 mmHg (SpO$_2$ > 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 O$_2$ 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 SpO$_2$ = 88% while breathing room air PLUS a demonstrable improvement in exercise performance on supplemental O$_2$ PLUS the following additional information –
   1. Minimum O$_2$ flowrate required to achieve improvement
   2. Patient’s mobility status

3. NOCTURNAL
   Evidence of oxygen desaturation to SpO$_2$ = 88% based on continuous overnight SpO$_2$ monitoring during sleep. SpO$_2$ = 88% should occur for greater than 1/3 of the sleep time. Identify the O$_2$ flowrate that maintains SpO$_2$ > 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 (SpO$_2$ < 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 PaO$_2$ = 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.
### 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  
- Is life expectancy < 3 months  

### SECTION 4: SMOKING HISTORY

**Status:**

- [ ] Never  
- [ ] Current  
- [ ] Ex

**Average cigs/day:**  

**Years smoked:**  

**Date ceased:** ____/____/____

### SECTION 5: DIAGNOSTIC GROUP (list details)

- [ ] COPD  
- [ ] Cardiac  
- [ ] DILD  
- [ ] Cancer  
- [ ] Asthma  
- [ ] Other

### SECTION 6: MEDICAL EVIDENCE OF

- [ ] Right Heart Failure  
- [ ] Polycythaemia  
- [ ] Pulmonary Hypertension

### 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:** ____/____/____
## Section 11: Arterial Blood Gases

<table>
<thead>
<tr>
<th>Date: / /</th>
<th>Room Air</th>
<th>Supp O2</th>
</tr>
</thead>
<tbody>
<tr>
<td>O₂ Flow (L/min):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pH:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PaCO₂ (mmHg):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PaO₂ (mmHg):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SaO₂ (%):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Section 13: Exertional Oxygen Assessment – 6 Minute Walk Test

<table>
<thead>
<tr>
<th>Date: / /</th>
<th>Room Air</th>
<th>Supp O2</th>
</tr>
</thead>
<tbody>
<tr>
<td>O₂ Flow (L/min):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rest</td>
<td>SpO₂ (%):</td>
<td></td>
</tr>
<tr>
<td>HR (bpm):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Borg Score:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End exercise</td>
<td>SpO₂ (%):</td>
<td></td>
</tr>
<tr>
<td>HR (bpm):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Borg Score:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distance (m):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recovery Time:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Section 14: Mobility Assessment:

- [ ] Ambulant and independent
- [ ] Ambulant with mobility aid –
  - [ ] walking frame with basket
  - [ ] stick
  - [ ] crutches
- [ ] Non-ambulant –
  - [ ] wheelchair
  - [ ] scooter

## Section 15: Oxygen Requirements

<table>
<thead>
<tr>
<th>Tick options and specify O₂ flowrate and usage</th>
<th>O₂ Flow (L/min)</th>
<th>Usage (hrs/day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen Concentrator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] Continuous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] Palliative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] Nocturnal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portable Oxygen</td>
<td>Type</td>
<td>Cylinder</td>
</tr>
<tr>
<td>(Complete section 13 &amp; 14)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] Exertional</td>
<td>Carry Bag</td>
<td>200 L PRN</td>
</tr>
<tr>
<td>[ ] Palliative</td>
<td>Trolley</td>
<td>400 L PRN</td>
</tr>
<tr>
<td></td>
<td></td>
<td>600 L PRN</td>
</tr>
<tr>
<td>Emergency</td>
<td>Asthma Kit: 1500 L Cylinder Kit</td>
<td>PRN</td>
</tr>
</tbody>
</table>