

Domiciliary Oxygen Request Instructions and Application Form

Please note that incomplete forms cannot be processed.

Requests must be submitted before 1:00 PM one business day prior to patient discharge. Equipment deliveries can only be scheduled Monday-Friday.

PAGE 1: Summary of indications for domiciliary oxygen upon discharge from hospital

PAGE 3-4: Application form. Please complete all relevant sections. Incomplete forms will be returned.

SUMMARY OF INDICATIONS FOR DISCHARGE HOME OXYGEN SET-UP

Oxygen is supplied in accordance with the guidelines of the Thoracic Society of Australia & New Zealand. 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. SWEP Guidelines for the Provision of Oxygen.
3. DVA Procedural Guidelines for Home Medical Oxygen Therapy.

1. CONTINUOUS
 1. PaO₂ ≤ 55 mmHg. An ABG must be taken at rest, after 20 minutes on room air and on optimal treatment. **ABG must be taken within 48 hours from discharge date**
 2. PaO₂ 56 - 59 mmHg With evidence of right heart failure, pulmonary hypertension or polycythaemia. **You must submit documentation with evidence of one or more of these conditions with the application form.**
 - Identify the minimum O₂ flow which maintains SpO₂ > 90% (PaO₂ > 60 mmHg)
 - Prescription should be for **≥18 hours/day** to achieve medical benefit
 - If the above criteria is met, the patient will be provided with an oxygen concentrator and 2 cylinders to meet their needs for 30 days after discharge
 - About **30%** of patients do NOT meet the criteria for long term continuous oxygen therapy when reviewed 4-6 weeks post discharge (Eaton, Grey, & Garrett, 2001, doi:10.1053/rmed.2001.1106)
2. EXERTIONAL **Exertional oxygen cannot be provided upon discharge.** An oxygen assessment may be conducted once the patient is in a stable phase of the condition, at least 30 days post discharge from hospital, to assess exertional oxygen requirements. If a referral is sent, this assessment can be done at the oxygen clinic.
3. NOCTURNAL **Nocturnal oxygen cannot be provided upon discharge.** If a patient is suspected to require nocturnal oxygen, they may be referred to the Respiratory Clinic for a consultation with a respiratory physician as an outpatient.
4. PALLIATIVE **Palliative patients must meet the same criteria as above - see 1. Continuous.**

RE-ASSESSMENT REQUIREMENTS

Clinical re-assessment is required for **ALL** discharge set-ups at least 30 days post hospital discharge, when the patient is in a stable phase of the condition, in order to determine the ongoing oxygen requirements. This assessment will be done at the Oxygen Clinic unless otherwise stated in the request form. **The Austin will fund oxygen equipment costs for the first 30 days after discharge. Requirements as outlined above must be met for continuation of oxygen therapy at the 30 day review. If they are met, the Oxygen Clinic will apply for ongoing funding for the patient.**

CONTRA-INDICATIONS

1. Chronic condition 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.



Domiciliary Oxygen Request

U.R Number
Surname
Given Name(s)
Date of Birth

AFFIX PATIENT LABEL HERE



FAH022415

SECTION 1 – Patient Details

Surname First Name

DOB/...../..... Sex M F DVA# / UR#

Address

Suburb Post Code.....Phone

Next of kin

NameRelationshipPhone

GP details

NameAddressPhone

Does patient have aged or homecare funding in place? No Yes

Service Name.....

Case Manager..... Phone.....Mobile.....

Patient location at time of request

Hospital Name & Ward Phone

Expected discharge date/...../.....

Does patient already have home oxygen? No Yes

If yes, supplierCurrent prescription for usage?.....L/minhrs/day

SECTION 2 – Delivery Address

Patient's home (as above)

Other address:.....Suburb:.....Postcode:.....

SECTION 3 – Diagnostic Group

COPD (Chronic Obstructive Pulmonary Disease) ILD (Interstitial Lung Disease)

Cancer Cardiac Other

Domiciliary Oxygen Request

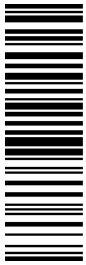
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Domiciliary Oxygen Request

U.R Number
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| | |
|------------------------------------|-------------------------------------|
| SECTION 4 – Smoking History | SECTION 5 – Medical Evidence |
|------------------------------------|-------------------------------------|

Status Never Current Ex-smoker
 Date ceased/...../.....
 Average cigarettes/day.....Years smoked.....

Right heart failure Yes No
 Polycythaemia Yes No
 Pulmonary hypertension Yes No
Attach supporting documentation

SECTION 6 – Four Week Review Arrangements

The Oxygen Clinic will re-assess the patient 30 days after discharge unless otherwise stated below.
 Patient will be reviewed by..... on/...../.....

SECTION 7 – Arterial Blood Gases

| | | |
|------------------------|-----------|------------------------|
| Date/...../..... | Room Air* | Supp O ₂ ** |
| O2 Flow Rate (L/Min) | | |
| pH | | |
| PaCO2 (mmHg) | | |
| PaO2 (mmHg) | | |
| SaO2 (%) | | |

* You must provide a resting room air ABG for approval of continuous oxygen taken within **48 hours** from discharge date.
 ** Please consider collecting an ABG on oxygen for patients with Type 2 Respiratory Failure.

SECTION 8 – Oxygen Prescription

| | |
|--------------------|---|
| O2 FlowL/min | Usage (recommended ≥18 hrs/day).....hrs/day |
|--------------------|---|

SECTION 9 – Requesting Physician

Title Name Specialty
 OrganisationAddress
 SuburbPost Code Phone Pager
 Signed Date/...../.....Provider Number

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