Austin Health

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. PaO_2 ≤ 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. PaO_2 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 O_2 flow which maintains SpO_2 > 90% (PaO_2 > 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.

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FAH022415

Austin Health

Domiciliary Oxygen Request

U.R Number ……

Surname ……

Given Name(s) ……

Date of Birth ……

AFFIX PATIENT LABEL HERE

SECTION 1 – Patient Details

Surname …….. .First Name ……..…..

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

Address ……

Suburb …… Post Code……..……..Phone …….....

Next of kin

Name ……...Relationship ……Phone …….....

GP details

Name ……Address ……...Phone …….....

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, supplier ……Current prescription for usage?.....L/min ….....hrs/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

M8.44

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U.R Number ……

Surname ……..

Given Name(s) ……

Date of Birth ..……

AFFIX PATIENT LABEL HERE

SECTION 4 – Smoking History

Status ☐ Never ☐ Current ☐ Ex-smoker

Date ceased ……/……../…….

Average cigarettes/day……Years smoked..……..

SECTION 5 – Medical Evidence

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 Flow ……..L/min

Usage (recommended ≥18 hrs/day)……..……..…hrs/day

SECTION 9 – Requesting Physician

Title …….. Name ……..……..... Specialty ……..…..

Organisation ……...Address ……..……..……..

Suburb ……Post Code ……..…… Phone ……...…….. Pager ……..…

Signed …… Date ……./……/…….Provider Number ……..…....

Domiciliary Oxygen Request

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