Non-VA or Community Hospital Home O2 Discharge Order form

ORL VAMC Lake Nona Home Oxygen, 0730-1530 hours Monday-Friday only,
FAX# 407-513-9157 Home O2 Clinic tel:407-631-2759

Weekends, Holidays, Evenings, Nights (WHEN) hours 0700-0700 hours
WHEN HOURS Contact: Tel:321-320-2746 FAX#407-631-2920

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Note: Patients **cannot be Discharged** with Oxygen after normal business hours if:
*Veteran has resting SPO2 ≤ 80% or requires ≥ 4LPM or Veteran is Tracheostomy patient

- ✓ Veteran's Name: _____ Last 4 of SSN_____ DOB _____
- ✓ Hosp Room# _____ Anticipated discharge date _____
- ✓ Veteran Emergency contact Name _____ Contact # _____
  - ➢ **Facility name & contact # of Discharge planner/ case worker making referral**
- ✓ Hospital and address: _____
  PRINT Case Mgr. Name & Direct dial Tel#
  _____
- ✓ Smoker Yes / No Diagnosis: _____Date of assessment_____

* Patient MUST qualify using 1 of 3 criteria below (A, B, or C). Assessment for O2 must occur <48 hours prior to Discharge or while patient is in chronic stable state.

A: Medicare/ORL VAMC qualifying criteria for Oxygen when resting:

(1) Resting SPO2 must be ≤ 88% or PO2 ≤ 55 mm hg,
(2) Resting PO2 ≥ 56 mm hg & ≤ 59 mm hg
(3) SPO2 ≤ 89% with clinical/laboratory findings such as: Pulmonary HPTN, Cor Pulmonale, Erythrocytosis, Erythrocythemia, Polycythemia (e.g. Hematocrit ≥ 55%)…

- ✓ At rest/room air SPO2%=_____ or PO2_____% Date of Assessment: _____

B: MEDICARE/6-Minute Walk Test standard (Room air SPO2≤88% to qualify)

SPO2@ rest=_____%, SPO2= _____% during exertion, (≤ 88% on room air w exertion to qualify,)
AND given ____ LPM (to reach minimum SPO2=90%,), Ending SPO2_____% w Oxygen (Minimum 90%)

C: ORL VAMC qualifying criteria for Oxygen during sleep, fax documents as well

* If oxygen is needed for sleep ONLY then Overnight Oximetry results must show:
  (1) PO2 must be ≤ 55 mm Hg from ABG, SPO2≤ 88% for at least 5 minutes during sleep or decrease in Arterial PO2 of > than 10 mm Hg or ⇩ in SPO2 > 5% for more than 5 minutes measured during sleep
  (2) SPO2____% during sleep or PO2 _____ Date of Assessment _____

Oxygen Prescription: If Patient meets OVAMC qualifying criteria above, please provide the info:

(1) Flow rate prescribed: _____LPM or FIO2 _____%,

* Nasal Cannula ___, Venturi-Mask ____, Trach Mask ___, Trach Venturi adapter ____, Continuous aerosol _____
* Other (specify) _____

Hospital Discharge Planner: Name & Signature _____