# Non-VA or Community Hospital Home O2 Discharge Order Form

**For Discharges: Mon-Fri 730:am-3:30pm Contact: Phone: 407-961-8536 Fax: 407-513-9157**
**For Discharges: Mon-Fri 3:30pm-7:30am including Weekends, Holidays, Evenings, Nights (W.H.E.N)**
**Contact: Phone: 321-320-2746 or Back up 321-319-6083; Fax: 407-631-2920**

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***** NOTE: Patient can NOT be discharged with oxygen after normal business hours Mon-Fri or weekend (Saturday and Sunday) if patient: Has a resting SpO2 ≤ 80% or Patient requires ≥4lpm oxygen or Patient has a tracheostomy/laryngectomy.**

**To Initiate the Oxygen Prescription Process please contact designated phone number listed above. Provide the following information for Home Oxygen Issuance prior to hospital discharge:**

Patient / Facility Information:

- **Patient Name: _____ Last Four Of SS#: _____ DOB: _____**
- **Diagnosis: _____**
- **Patient Residential address:**
  **_____**
- **Emergency Contact (name/number):**
  **_____**
- **Hospital: _____ Room #: _____ Anticipated Discharge: _____**
- **Case Manager/Discharge Planner: _____ Phone: _____Ext: _____**

**OVAHCS Qualifying Criteria (A, B, or C).). Assessment for oxygen under criteria A or B must occur no earlier than 2 days prior to discharge or while the patient is in a chronic stable state.**

***A. OVAHCS Qualifying Criteria for Oxygen When Resting:***

- On Room Air: Resting SpO2 must be ≤88% **OR** Arterial Blood Gas sample with PaO2 ≤55 mmHg.
- On Room Air: Resting PaO2 ≥56 mm Hg and ≤59 mm Hg **OR** SpO2 ≤89% with clinical or laboratory findings such as Pulmonary Hypertension, Cor Pulmonale, Erythrocytosis, Erythrocythemia, Polycythemia (e.g., Hematocrit ≥55%).
- Date and Test results:

At rest on Room Air: SpO2 _____ % **or** PaO2 _____mmHg

**** If resting SpO2% is ≤88% (on room air), place patient on oxygen therapy to stabilize patient at SpO2 90-92% prior to start of exertion and document below:**

At rest (oxygen applied at baseline prior to exertion): Liters per minute (lpm) ___ SpO2 ____%

***B. OVAHCS Qualifying Criteria for Oxygen on Exertion:***

## **During exertion (i.e., 6-minute walk test)

☐ SpO2 during exertion **(start)** _____ % (≤ 88% **on room air** with exertion to qualify)
☐ Oxygen applied and patient stable (minimum 90% SpO2): ____ liters per minute applied
☐ SpO2 w/Oxygen **(ending)**_____% at Liters per Minute____ (ensure SpO2 ≥ 90%)

***C. OVAHCS Qualifying Criteria For Oxygen During Sleep*:**
***If oxygen is needed for sleep ONLY, Overnight Oximetry or ABG results documenting need must be within last 30 days.**

Criteria: PaO2 ≤ 55 mm Hg, SpO2 ≤88% for at least 5 minutes during sleep or decrease in Arterial PaO2 > 10 mm Hg or decrease in saturation more than 5% for more than 5 minutes taken during sleep.

- During sleep: SpO2_____ % or PaO2_____ Date of Assessment: _____

## OXYGEN PRESCRIPTION

**If Patient meets OVAHCS qualifying criteria above, please provide the following information**:

**Flow rate prescribed based on documented assessment above:**

At Rest (if applicable): _____liter per minute

On Exertion (if applicable): _____liter per minute

During Sleep (if applicable): _____liter per minute

**Mode of delivery (circle one):**

- Nasal Cannula: Yes or No (if no, specify below)
- Other (please specify): _____

**Is a portable system/oxygen tank required for transport from facility? Yes _____ No_____**

**Smoking History: **Circle response as applicable**

- Active Smoker: Yes or No
- Smoking History: Yes or No (if yes, when did patient quit?) _____
- Smoke Detectors: Yes or No
- Infection control Alerts: Yes of No

**Ordering Physician (Print/Sign): _____ Date: _____**

**Fax:** ***** ALL below items are REQUIRED documentation to be faxed to the number listed at top of this form if any of the following were performed to document need for oxygen, please include copies.***

- ✓ **Discharge Order Form ("this form")**
- ✓ **Six Minute Walk Test**
- ✓ **Arterial Blood Gas (if applicable)**
- ✓ **Overnight Oximetry (if applicable)**

# DO NOT FAX ENTIRE MEDICAL RECORD

**Cannot fulfill prescription without MD signature**

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