FM.O3.1 9/20

Patient Label

All inpatient and urgent outpatient requests must be reviewed by a Respiratory Nurse.

Respiratory Nurse Name ____________________
(printed)

Signature ____________________

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

OXYGEN PRESCRIPTION & PATIENT CONSENT

Refer to Protocol 'CPM 02.7
OXYGEN THERAPY — COMMUNITY SUPPLY

Refer to Respiratory Nurse for education and equipment supply

I have had explained to me and understand and consent to:

- **That I am aware if I smoke or vape the oxygen will be removed immediately.**
- That oxygen is a prescribed medication. My oxygen must be used as prescribed to me and the oxygen suppliers legally cannot supply more than is prescribed.
- That I am responsible for the care of the equipment. If lost, stolen or damaged I will be responsible for payment of all costs.
- There is an electrical cost with the concentrator which may be subsidised.

If phone number and delivery address is different from above please document here

Patient signature:

Date:

Health professional signature:

Date:

Print Name:

Care provided by: ☐ DN (diagnosis = ____________________)
☐ Referred to Hospice, waiting assessment. Phone Hospice Referral Team

EQUIPMENT REQUIRED

Description Number	Number Required
Adult concentrator, tubing, connector and nasal cannula	
Adult regulator 0-15 LPM - with nasal cannula for cylinder use	
Oxygen cylinder - small (400 litre) Maximum per week →	
Oxygen cylinder - medium (**ONLY** if oxygen saturation on room air is below 88%)	
For Paediatric equipment contact Paediatric team to process request	
Paediatric Regulator →	
Paediatric Concentrator →	

ADULT OXYGEN CONCENTRATOR _____ litres per minute

☐ PRN use over 2 hours ☐ Use over 16 hours

CYLINDERS _____ litres per minute

☐ For Mobilising ☐ Short Burst Oxygen

Prescriber Name: ____________________

Designation: ____________________

Prescribers Number: ____________________

Signature: ____________________

Criteria for oxygen overleaf

ARTERIAL BLOOD GASES

DATE:	
pH	pCO_2
pO_2	HCO_3
O_2 saturation	

List hospital equipment given at discharge over leaf.

Note any home hazards for staff visiting

☐ For Level 5 patients send this form directly to the rest home.

Inpatient

Discharge date: ________ Time: ________

Delivery date: ____________________

Outpatient

Delivery ☐ ASAP
☐ Next rostered delivery day

COMMENTS

EQUIPMENT GIVEN TO PATIENT
(please record equipment numbers)

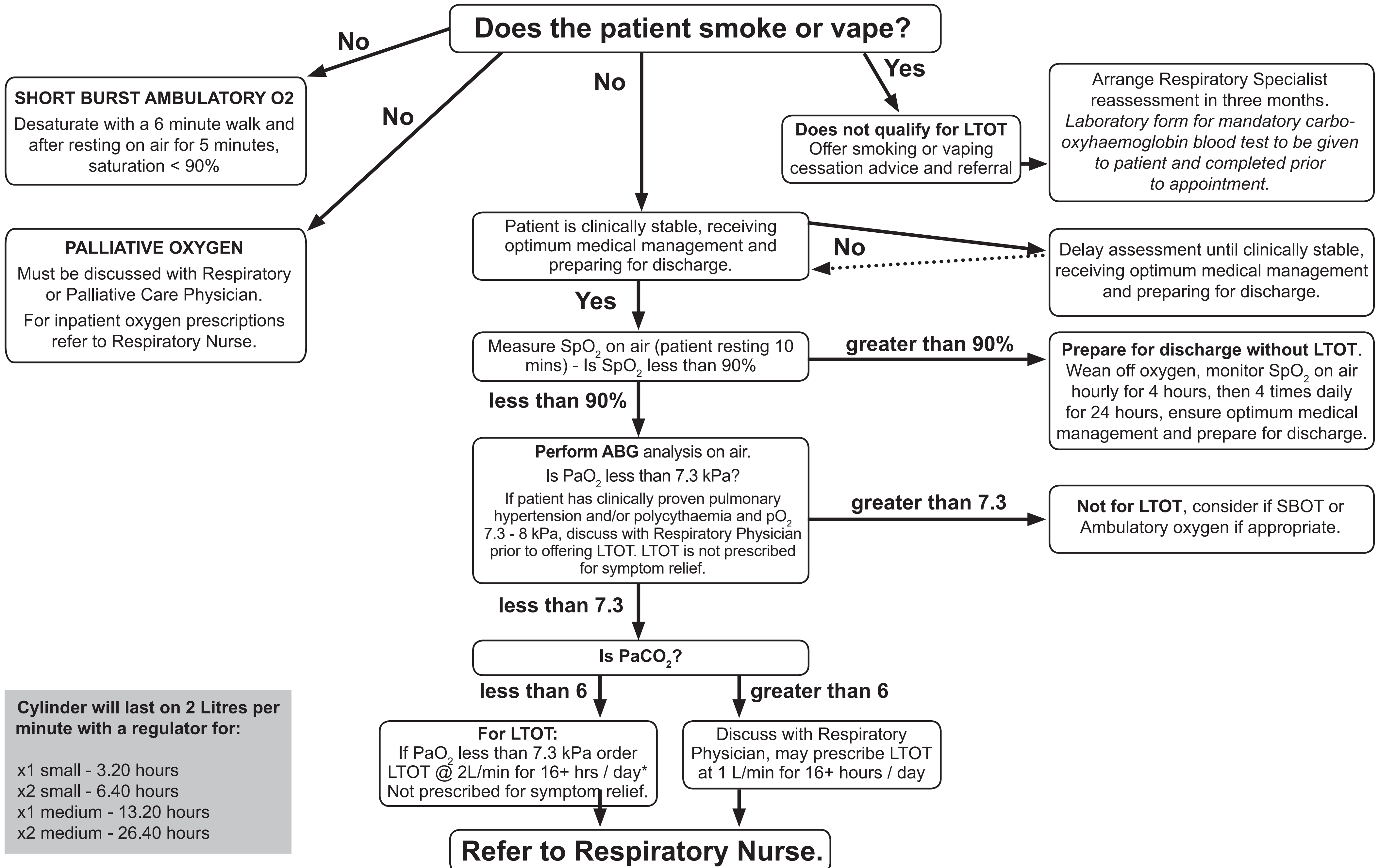
Concentrator # BM____________________

Regulator # BMR____________________

Cylinder batch # ____________________

ASSESSMENT FOR LONG TERM OXYGEN THERAPY (LTOT, COPD)

Please note that this flowchart generally relates to COPD. Please discuss all patients including palliative with a Respiratory Physician (Tauranga) or General Physician (Whakatane)



Cylinder will last on 2 Litres per minute with a regulator for:

x1 small - 3.20 hours
x2 small - 6.40 hours
x1 medium - 13.20 hours
x2 medium - 26.40 hours