



Non-VA HOSPITAL DISCHARGE ORDER FORM

ORLANDO HOME OXYGEN PROGRAM: Ph: 407-631-2759 **FAX:** 407-513-9695 or 407-513-9157

VIERA HOME OXYGEN: Ph: 321-637-3788 Ext. 2735/2701 **DAYTONA HOME OXYGEN:** Ph: 386-323-7500 Ext. 37630 or 386-947-2222

For Discharges after 4 pm Mon-Fri, or on Weekends, or Holidays,

contact the After Hours Coordinator *first:* Ph: 321-320-2654, then Fax: 407-643-9338

*** NOTE: Patient can NOT be discharged with oxygen after normal business hours Mon-Fri IF :**

- **Patient has resting sPO2 ≤80% or Patient requires ≥4lpm oxygen or Patient is a tracheostomy patient**

1. To Initiate the Oxygen Prescription Process please **Contact Home Oxygen Coordinator at designated phone numbers listed above**

Please provide the following information for Home Oxygen Issuance prior to discharge:

- Patient Information:
 - Name: _____ Last Four Of SS#: _____ DOB: _____
 - Room#: _____ Anticipated Date Of Discharge: _____
 - Emergency Contact Person & Phone Number: _____
- Facility name and phone number of the person making the referral:
 - Hospital: _____ Contact Person: _____ Phone: _____ Ext.: _____
 - Patient's diagnosis: _____

*** Patient must qualify using one of the 3 criteria below (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. OVAMC Qualifying Criteria For Oxygen When Resting:

- Resting SpO2 must be ≤88% **OR** P02 ≤55 mmHg
- Resting P02 ≥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: PO2 _____ or SP02 _____ % Date of Assessment: _____

B. OVAMC Qualifying Criteria For Oxygen on Exertion :

- ✓ SP02 at rest _____ % , Sp02 during exercise: _____ % , (Sp02 must be ≤88% on Room Air with exertion to qualify).
- ✓ Must then measure with patient on prescribed oxygen: SP02 with O2 during exercise _____ % at _____ LPM or _____ FiO2
Date of Assessment: _____

C. OVAMC Qualifying Criteria For Oxygen During Sleep:

***If oxygen is needed for sleep ONLY then Overnight Oximetry or ABG results documenting need must be within last 30 days.**

- ✓ I. P02 must be at or below 55 mm Hg, Sp02 ≤88% for at least 5 minutes during sleep or decrease in Arterial P02 of more than 10 mm Hg or decrease in saturation more than 5% for more than 5 minutes taken during sleep.
- ✓ During sleep: Sp02 _____ % or PO2 _____ Date of Assessment: _____

OXYGEN PRESCRIPTION

➔ If Patient meets OVAMC qualifying criteria above, please provide the following information:

- Flow rate prescribed: _____ liters per minute (LPM) or FiO2 _____ %
 - Nasal Cannula Venturi-Mask Trach Mask Trach Venturi Adapter Continuous Aerosol
 - Other (Please Specify) _____ Is a portable system required for transport from facility ? : Yes No

Fax this completed form along with the REQUIRED documentation to the appropriate fax number listed above. If any of the following were performed to document need for oxygen, please include copies: ABGs, overnight oximetry, Sleep Study or 6 Min Walk tests. Missing documentation will delay processing the oxygen therapy order. Oxygen orders are processed the SAME DAY unless specified.

Discharge Hospital Community Nurse Planner: _____ Date: _____