



## Non-VA Hospital Discharge Order form

Lake Nona Home Oxygen, [Tel: 407-631-2759](tel:407-631-2759) FAX# [407-513-9157](tel:407-513-9157) (0730-1600 hours)

Daytona Home Oxygen, [Tel:386-323-7500](tel:386-323-7500) ext: 37630 or [Tel:386-947-2222](tel:386-947-2222)

Viera Home Oxygen, [Tel:321-637-3788](tel:321-637-3788) ext: 2701 or 2735

Discharges after 1600 hours, Weekends and Holidays,

Contact AFTER HOURS , [Tel:321-320-2746](tel:321-320-2746) / [3629](tel:321-320-3629) Fax# 407-631-2920

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 \_\_\_\_\_

✓ Emergency contact Name \_\_\_\_\_ Contact # \_\_\_\_\_

➤ **Facility name & contact # of case worker making referral**

➤ Hospital: \_\_\_\_\_ Contact# \_\_\_\_\_

➤ 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: OVAMC 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%=\_\_\_\_\_ PO2\_\_\_\_\_%

**B: OVAMC qualifying criteria for Oxygen on Exertion:** (Room air SPO2≤88% to qualify)

SPO2@ rest=\_\_\_\_%, SPO2=\_\_\_\_% during exertion, SPO2% \_\_\_\_\_ after correction w \_\_\_\_LPM or \_\_\_\_FIO2

**C: OVAMC qualifying criteria for Oxygen during sleep:**

\* If oxygen is needed for sleep ONLY then overnight Oximetry or

\* ABG results documented must be within last 30 days.

(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 taken 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) \_\_\_\_\_, Is portable system required for transport (Y / N)\_\_\_\_\_

➤ Fax this completed form along with **REQUIRED** documentation to the appropriate fax# listed above.

➤ Please attach copies of results of: ABG tests, overnight oximetry tests, sleep study or 6 Minute Walk Tests.

➤ Missing documents will delay processing the Oxygen Therapy order. Oxygen orders are processed same day

DISCHARGE HOSPITAL COMMUNITY CARE PLANNER: \_\_\_\_\_

DATE: \_\_\_\_\_ Note/s: \_\_\_\_\_