



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

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 and address: _____
 PRINT Case Mgr. & 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%=_____ PO2_____%

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

SPO2@ rest=____%, Desaturated to SPO2= _____% during/after exertion, and then Corrected w ____ LPM (to reach minimum SPO2=90%, as per Medicare Standard policy)

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) _____

- 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

Case Mgr./Social Worker Name & Signature _____