

# VICTORIAN AIDS AND EQUIPMENT PROGRAM: REQUEST FOR DOMICILIARY OXYGEN

<b>Client Details</b> (or affix UR Label)	
	UR Number _____
Name	_____
Address	_____ _____
Date of Birth	_____ Gender _____
Phone	_____ Discharge Date _____
Hospital	_____

**PLEASE ENSURE ALL SECTIONS ARE COMPLETED OR ACKNOWLEDGED**

## DIAGNOSIS AND OXYGEN REQUIREMENTS

**Adults**

Evidence of

- COPD
- DILD
- Cor pulmonale
- Pulmonary hypertension
- Exercise-related hypoxia
- Sleep apnoea
- Terminal malignancy
- Advanced non-pulmonary or cardiac disease
- Other:

Applicant is

- On maximal therapy
- Clinically stable
- Non-smoker

Note that active smokers are ineligible

Applicant and/or carer is

- Able to understand and willing to abide by the safety requirements

**Children**

Continuous Oxygen

- Oxygen-dependent lung disease (including BPD)
- Cystic fibrosis with arterial oxygen desaturation
- Palliative care

Intermittent oxygen

- Severe life-threatening asthma (and living in remote area)
- Cystic fibrosis with desaturation during exercise
- Recurrent severe life-threatening upper airway obstruction

Nocturnal oxygen

- Central hypoventilation with hypoxaemia during sleep
- Cystic fibrosis with sleep-related hypoxaemia
- Recurrent apnoea of infancy that is otherwise therapeutically unresponsive

Other:

Applicant and/or carer is

- Able to understand and willing to abide by the safety requirements

**SPIROMETRY AND DIFFUSING CAPACITY** Ensure supporting documentation is attached DATE \_\_\_\_\_

	Predicted	Pre bronchodilator	Post bronchodilator
FEV <sub>1</sub>			
FVC			
FEV <sub>1</sub> /FVC%			
DLCO			

**BLOOD GASES (initial test)** Ensure supporting documentation is attached DATE \_\_\_\_\_

	Flow rate	pH	PaCO <sub>2</sub>	PO <sub>2</sub>	SaO <sub>2</sub>	COHb	Hb
Air	-						
Intranasal O <sub>2</sub>							
Intranasal O <sub>2</sub>							

**BLOOD GASES (retest)** Ensure supporting documentation is attached DATE \_\_\_\_\_

	Flow rate	pH	PaCO <sub>2</sub>	PO <sub>2</sub>	SaO <sub>2</sub>	COHb	Hb
Air	-						
Intranasal O <sub>2</sub>							
Intranasal O <sub>2</sub>							

**EXERCISE TEST** (six minute walking test with oximetry) DATE \_\_\_\_\_

**AIR**

	Rest	1 min	2 min	3 min	4 min	5 min	6 min
Pulse							
% Saturation							

**INTRANASAL OXYGEN WITH CONSERVATION DEVICE SETTING** \_\_\_\_\_ L/min

Pulse							
% Saturation							

**VICTORIAN AIDS AND EQUIPMENT PROGRAM REQUEST FOR DOMICILIARY OXYGEN**

Name \_\_\_\_\_  
 DOB \_\_\_\_\_ UR Number \_\_\_\_\_

**OXYGEN REQUIREMENTS**  
**Oxygen via**       Face mask       Nasal cannula  
**Duration of therapy**       Nocturnal       Intermittent       Continuous \_\_\_\_\_ hrs/day  
**Flow rate** \_\_\_\_\_ L/min  
**Regulators / Flow meters (children)**       Low flow       High flow

**EQUIPMENT**

**Concentrator**  
 **Portable cylinders**      Size \_\_\_\_\_ Number \_\_\_\_\_  
 **Back-up cylinders**      Size \_\_\_\_\_ Number \_\_\_\_\_  
 Justification \_\_\_\_\_  
 **Accessories**       Conservation device  
                                   Stroller kit  
                                   Carry bag  
                                   Other \_\_\_\_\_

**FURTHER COMMENTS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ADDITIONAL QUESTIONS**

Was oxygen required on discharge from hospital?       Yes       No  
 Was oxygen supplied free of charge for 30 days following discharge?       Yes       No  
 Is client currently receiving oxygen therapy?       Yes       No  
 If so, please state supply company \_\_\_\_\_

**LABORATORY / TESTING FACILITY CONTACT (if applicable)**

Name \_\_\_\_\_ Job Title \_\_\_\_\_  
 Pager No \_\_\_\_\_ Phone No \_\_\_\_\_ Department \_\_\_\_\_

**PRESCRIBING PHYSICIAN**

Name (please print) \_\_\_\_\_ Phone no \_\_\_\_\_  
 Address \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

Provision of funding for oxygen gas and associated equipment for domiciliary oxygen therapy will be in accordance with the guidelines established by the Thoracic Society of Australia and New Zealand (TSANZ).

- for further details on provision of oxygen for adults see Medical Journal of Australia 1998;168:21-25 at [www.thoracic.org.au](http://www.thoracic.org.au)  
 - for further details on children see TSANZ Position Paper, Domiciliary oxygen therapy in children, J.Paediatr.Child Health (1993) 29, 259 - 262

**DEPARTMENT OF HUMAN SERVICES RESPIRATORY CONSULTANT**

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Approved       Not Approved  
 Signature \_\_\_\_\_ Date \_\_\_\_\_