MONASH LUNG AND SLEEP
MonashHealth

Email: monashoxygenprogram@monashhealth.org
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Affix patient Identification Label

SHF009409w

Home Oxygen Consent

Name of Person Obtaining Consent

Surname:_____ **First name:**_____ **Position:**_____

Signature:_____ **Date:** _____/_____/_____

- ☐ I confirm that I am the patient named above/ I have parental responsibility for the child named above. My doctor has clearly explained the need for the prescription of oxygen at home.
- ☐ I understand that Monash Health will provide the necessary clinical and demographic information to the company supplying the oxygen equipment.
- ☐ I confirm that I have received an oxygen information brochure and I am aware that further training will be given by the oxygen supplier upon delivery. I agree to follow all safety requirements and to use the oxygen as prescribed by my doctor.
- ☐ I confirm that I am a non-smoker and that oxygen funding will ceased if there is evidence that I am smoking.
- ☐ I understand that I will be required to attend an oxygen review appointment 30-60 days post discharge. If I choose not to attend this appointment, I agree to accept all ongoing prescription costs.

Patient name: _____ **Patient signature:** _____

Date: _____/_____/_____

Next of kin Name: _____ **Contact Number:** _____

Hospital Oxygen Discharge Prescription

Primary Diagnosis

☐ COPD ☐ DILD ☐ Palliative ☐ Paediatric ☐ Other

Resting Arterial Gases

	Oxygen	pH	PaCO2	PaO2	SaO2
Baseline	RA				

Flow rate required to maintain **Resting SaO2** of **>90%**: _____ L/min

Six Minute Walk Test

Does this patient desaturate to **<88%** on a Six Minute Walk Test? Yes / No

Flow rate required to maintain **Ambulatory SaO2** of **>90%**: _____ L/min

Duration of Therapy

- ☐ Continuous
- ☐ Portable
- ☐ Nocturnal (Please attach sleep study)

Please ensure the following is completed before discharge:

- ☐ Education brochure
- ☐ Consent form
- ☐ Confirm patient has ceased smoking for min. 6 wks as an outpatient (incl e-cigarettes)

Discharge information

Intended Date of Discharge: ____/____/_____

Name of Prescribing Physician: _____ Signature_____

Provider #: _____ Mobile #:_____ Pager #: _____

☐ SMR referral submitted for oxygen outpatient review

Admission/ Outpatients Divider

DOMICILIARY OXYGEN CONSENT AND DISCHARGE PRESCRIPTION