

## Oxygen Patient Visit Equipment Check List

**Technician to complete this section prior to performing the home visit**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Prescribed Stationary Flow Rate: \_\_\_\_\_ Prescribed Portable liter flow \_\_\_\_\_

Patient has RX for OCD  Yes  No if yes list liter flow rate \_\_\_\_\_

Prescribed Delivery System \_\_\_\_\_

Prescribed Frequency of Use:  Nocturnal  As Needed  Continuous Flow  With Exercise

Prescribed Duration of Use:  Lifetime  Other \_\_\_\_\_

Internal-filter on patient's equipment was last changed \_\_\_\_\_ hours/date

Equipment Due for Preventative Maintenance  Yes  No

Current Hours \_\_\_\_\_ Serial Numbers \_\_\_\_\_

Next Due for Maintenance \_\_\_\_\_ hours/date

Oxygen Concentration % \_\_\_\_\_ *If below 90% at prescribed flow rate check manufacturers specifications and change out equipment if necessary*  
*If equipment was changed indicate here and complete delivery ticket*  Yes  No

Filters Cleaned/Changed  Yes  No

Alarm Checked  Yes  No

Stationary At prescribed Liter Flow  Yes  No

Does patient have an OCD  Yes  No

Flow Rates set to RX on OCD  Yes  No

Does Patient have a Back Up system  Yes  No

Was Backup/portable functioning properly  Yes  No N/A

**List # of Supplies Left (enter number in box)**

- |                                       |                                     |  |  |
|---------------------------------------|-------------------------------------|--|--|
| <input type="checkbox"/> Cannula Only | <input type="checkbox"/> 7' Tubing  | <input type="checkbox"/> Humidifiers   | <input type="checkbox"/> No Smoking Sign |
| <input type="checkbox"/> 4' Cannulas  | <input type="checkbox"/> 10' Tubing | <input type="checkbox"/> Water Traps   | <input type="checkbox"/> Other           |
| <input type="checkbox"/> 7' Cannulas  | <input type="checkbox"/> 25' Tubing | <input type="checkbox"/> e-z Wraps     | _____                                    |
| <input type="checkbox"/> 15' Cannulas | <input type="checkbox"/> 50' Tubing | <input type="checkbox"/> O2 Connectors |  |

**List # of Cylinders Patient Currently Has (enter number in box, if USP enter lot numbers on hand)**

- |                                 |  |              |
|---------------------------------|--|--------------|
| <input type="checkbox"/> M6 USP | <input type="checkbox"/> ML4 HomeFill/iffill | Others _____ |
| <input type="checkbox"/> C USP  | <input type="checkbox"/> ML6 HomeFill/iffill |              |
| <input type="checkbox"/> D USP  | <input type="checkbox"/> ML9 HomeFill/iffill |              |
| <input type="checkbox"/> E USP  |  |              |

Comments or issues of non-compliance that must be reported to the physician or list maintenance items performed:

\_\_\_\_\_

Patient/Caregiver \_\_\_\_\_ Date \_\_\_\_\_

Technician \_\_\_\_\_ Date \_\_\_\_\_