

POS0602-10/08

Professional Medical Oxygen Plan of Service

(to be performed on all non-institutional or commercial account Oxygen patients)

Patient Name: _____ Sex _____ DOB _____ Ht: _____ Wt: _____

Physical Address: _____ Phone _____

Caregiver Name: _____ Patient: lives alone w/family/friends facility

Emergency Contact/Responsible Party: _____ Emergency Phone: _____

Diagnosis _____ Physician _____

Name of Other Individuals/Organizations Involved in Care: (i.e. Home Health Agencies) _____

Social Activities (requiring portable oxygen): _____ Appx Hours per week _____

Oxygen Prescription _____ LPM At Rest _____ LPM With Exercise:

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

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

Smokers in the Home	<input type="checkbox"/> Yes (precautions given)	<input type="checkbox"/> No
Patient Given No Smoking Sign for placement on door/window	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient has open flame, fireplace, stove, furnace	<input type="checkbox"/> Yes (precautions given)	<input type="checkbox"/> No
Electrical plugs available and not overloaded	<input type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate
Fire Safety (Has smoke detectors/alarm and/or Extinguisher)	<input type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate
Are there Safety or Health Hazards Present	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Is the patient suitable for homecare	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Expand on any inadequacies:		

Equipment Setup as ordered by physician: (Check all that apply)

<input type="checkbox"/> Concentrator	<input type="checkbox"/> Nasal Cannulas
<input type="checkbox"/> Portable w/ regulator	<input type="checkbox"/> Humidifiers
<input type="checkbox"/> Cylinder sizes _____	<input type="checkbox"/> Supply Tubing and Connectors
<input type="checkbox"/> Oxygen Conserving Device	<input type="checkbox"/> Oxygen Mask (specific order & flow rate must be on file & will not work with conservers)
<input type="checkbox"/> Home Transfilling System	<input type="checkbox"/> Portable Oxygen Concentrator

Goal: Patient will be able to properly self-administer oxygen, give a return demonstration and maintain the equipment in a safe manner.

List Interventions necessary to achieve stated goals: _____

Special Needs/Functional Limitations: _____

Level of Ambulation: ambulates independently ambulates w/ assistance cane/walker requires O2 to ambulate non-ambulatory

Follow Up Schedule: to perform required preventative maintenance other _____

Plan of service review/updates: Professional Medical will review and update your plan of service anytime your physician makes changes to your oxygen prescription; such as with liter flow changes or changes in the delivery method. Additionally, we will update your plan of service anytime a change in your condition occurs which may affect the type of equipment that would be most appropriate for you. Please let us know if your condition changes so we may re-evaluate your service.

Discharge Plans: Oxygen is considered a drug and is regulated by the FDA. Due to various regulations and liability issues, if there was not a specific length of need included on your initial prescription, Professional Medical requires that your physician provide discharge orders prior to termination of, or changes in your oxygen service. If you are not using your oxygen, feel you no longer need oxygen, or believe that you require changes to your equipment, delivery method or flow rates, you will need to consult with your physician and provide us with a discontinuation or change orders. Refusal to consult with your physician will result in your being asked to sign an against medical advise statement at the time your equipment is returned. If you violate our instructions regarding liter flow or other equipment usage instructions we may be obligated to report this to your physician and under certain circumstances revoke service.

Prescribed Duration of Use: Lifetime Other _____

Client/Caregiver Signature _____

Technician Signature _____

Date _____