OXY0803-09/08

Clinical Respiratory Evaluation & Plan of Care

Patient Assessment

Patient Name:	Date of Birth:	Ht: Wt:	■ Male ❑ Female

Chief Complaint, Problem or Diagnosis(s):

Current Respiratory RX: *(include frequency, durations & equipment types)*

Date of Assessment:	Performed By:
Physician:	Physician Fax:
Patient Mental Status:	Smoking History/Smokers in the home:

Psychosocial Assessment: ❑ lives alone ❑ lives w/ family ❑ Other_____
List Caregivers or other individuals involved with care:

Home is suitable for homecare ❑ Yes ❑ No	Caregiver willing and able to assist patient ■ Yes ❑ No

Social Activities:

Functional Limitations/Activity Restrictions: ❑ None ❑ Paralysis ❑ Amputation ❑ Bed Confined
❑ Hearing Impaired ❑ Vision Impaired List Level of Ambulation:

Home Safety Assessed Home Safety Assessment Performed including electrical ■ Yes ❑ No	Patient Instructed on Safe Oxygen Use and Storage Practices ■ Yes ❑ No

No Smoking Sign ■ Yes ❑ No	Fire Extinguisher Present ❑ Yes ■ No	Smoke Alarm Present ■ Yes ❑ No

Physical Health: Airway: ❑ Normal ❑ Mouth Breather ❑ Tracheostomy ❑ Other_____

Economic: List existing challenges:

Evaluation

Clinician Findings:

Recommended Additions or Adjustments to current RX:

Outcomes/Goals:
- ❑ Maintain Compliance with the Physician's orders
- ❑ Be able to properly maintain & use the respiratory equipment in a safe effective manner
- ❑ Be able to give a return demonstration on the use of the equipment.
- ❑ Other:

Oximetry Test – Summary of Results

Oxygen Saturation at Rest *(indicate how test was performed):* ❑ _____% On Room Air ❑ _____% On _____LPM or % O_2	**Overnight Pulse Oximetry:** ❑ Oximetry Results Attached

Oxygen Saturation with Ambulation (indicate how test was performed):
❑ _____% On Room Air _____% On Conserving Device @ _____LPM
❑ _____% On _____LPM or % O_2

Patient Signature:_____Date:_____

Clinician Siganuture:_____Date:_____

Please note that certain clinical tests performed as part of the respiratory assessment are provided for the purposes of evaluating the patient's clinical needs. Further testing by a qualified laboratory or other such medical provider may be required in order to fulfill Medicare and Medicaid prescription requirements for Oxygen and Positive Airway Pressure Therapy.