HOME OXYGEN INFORMATIONAL FORM

The following information is required on beneficiaries receiving oxygen therapy. This, or a similar medical necessity form providing the same information, must be retained in the files of the provider supplying the oxygen contents, vessels and concentrators.

BENEFICIARY'S NAME: ____

BENEFICIARY'S ID#: ____

PRESCRIBING PHYSICIAN: ____

DATE 02 THERAPY STARTED: ____

FLOW/MINUTE: ____

METHOD OF ADMINISTRATION (cannula/mask): ________________________

INTERMITTENT OR CONTINUOUS: ____________________________________

Arterial Blood Gases:

Prior to Start of Therapy:	**Last Current:** **Arterial - YES____ NO ____** **Ear Oximeter - YES____ NO ____**
Date ________________________	**Date** ________________________
pH __________________________	**pH** __________________________
pC02 ________________________	**pC02** ________________________
p02 _________________________	**p02** _________________________
02 Sat. _____________________	**02 Sat.** _____________________
On or Off 02 ________________	**On or Off 02** ________________

ATTACH A COPY OF THE ORIGINAL AND/OR CURRENT RX TO THIS FORM

Breathing Treatments: **YES**_____ **NO**_____ **FREQUENCY**__________________

Comments: ____

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