

OXYGEN ORDER FORM



	Private patient? Yes <input type="checkbox"/> No <input type="checkbox"/>
Patient's name:	Address:
Date of birth:	
Next of kin:	
Medical card number:	Delivery address (if different):
Medical card expiry date:	
Telephone number:	Mobile telephone number:

Prescription details

Method of delivery

Nasal cannula required?: Mask required?:

if yes, please select: Venturi: 24% 28% 31% 35% 40% 60% OR Other type:
2 lpm 4 lpm 6 lpm 8 lpm 10 lpm 15 lpm

Oxygen concentrator

Oxygen concentrator required?: Yes No Homefill required?: Yes No

Oxygen flow rate: lpm 2 lpm 4 lpm

Hours per day: hours OR PRN

Humidifier required?: Yes No

Portable oxygen cylinder

Portable oxygen cylinder required?: Yes No

Oxygen flow rate: lpm/setting (a conserver will be supplied as standard – conserver settings 0.5-8 lpm)

Hours per day: hours OR PRN

If more than six (6) cylinders are required per month, please indicate how many: (6 is the normal starting amount)

Portable/transportable oxygen concentrator

Portable/transportable oxygen concentrator: SeQual Inogen One Inogen One G2

SeQual direct flow setting: 0.5 1.0 2.0 3.0 (lpm)

SeQual pulse dose setting: 1 (16ml) 1.5 (24ml) 2 (32ml) 2.5 (40ml) 3 (48ml)
3.5 (56ml) 4 (64ml) 4.5 (72ml) 5 (80ml) 5.5 (88ml)
6 (96ml) 128ml 160ml 192ml

Inogen One or Inogen One G2 pulse dose setting: 1 2 3 4 5

Hours per day: hours OR PRN Spare battery required? Yes No if yes, how many?

We advise that the patient is tested to ensure adequate saturation levels before prescribing a portable/transportable concentrator.

Additional details

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Prescribers details

Print name:	Hospital:
Signed:	Ward:
Date:	Bleep number:

Send to

Medical card patients: Fax to HSE PCCC for approval.

Non medical card patients: Fax direct to Air Liquide Healthcare.