| **VETERAN NAME:** | **PATIENT ID:** | | | | | | **REVIEW DATE:** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **MATERIAL NEEDED** | **ASSESSMENT OR RESPONSE** | | | | | | **REQUIRED FOLLOW-UP** |
| Do you have a copy of the current prescription? | Yes | | No | |  | |  |
| Do you have the last delivery/maintenance ticket (DMT)? | Yes | | No | |  | |  |
| **ASSESSMENT** | **ASSESSMENT OR RESPONSE** | | | | | | **REQUIRED FOLLOW-UP** |
| Was the below documented by the Vendor? |  | | | | | |  |
| 1. Are smoking materials in the home? | Yes | | No | |  | | *List type of smoking materials (e.g., cigarettes, cigars):* |
| 1. Did the Veteran verify that they do not smoke while using O2 and that they do not allow others to smoke within 10 feet of an oxygen concentrator in use? | Yes | | No | |  | |  |
| 1. Are there any identified safety risks, e.g., open flames? | Yes | | No | |  | | *If yes, list required actions for each risk:* |
| 1. Is a “NO SMOKING” sign at the home entrance? | Yes | | No | | N/A | |  |
| 1. Are there smoke detectors or a fire alarm system in the home? | Yes | | No | |  | | *List recommendations given to patient (if any):* |
| 1. Were smoke detectors or fire alarms recently tested? | Yes | | No | |  | | *List recommendations given to patient (if any):* |
| 1. Can the oxygen equipment be used safely, including grounded outlets, electrical cords, and no use of extension cords? | Yes | | No | |  | |  |
| 1. Does the Veteran have a fire evacuation and disaster plan and response? | Yes | | No | |  | |  |
| **EDUCATIONAL AND SUPPORT MATERIALS** | **ASSESSMENT OR RESPONSE** | | | | | | **REQUIRED FOLLOW-UP** |
| Did the Veteran or Veteran’s caregiver receive Home Oxygen Therapy handouts? | Yes | | No | |  | | *List handouts provided:* |
| Did the Veteran or Veteran’s caregiver receive information about Fall Risks? | Yes | | No | |  | | *List information provided:* |
| Has the Veteran or Veteran’s caregiver been informed that not using oxygen according to the prescription is dangerous? | Yes | | No | |  | |  |
| Did the Veteran or Veteran’s caregiver receive the Patients Rights and Responsibilities? | Yes | | No | |  | |  |
| Did the Veteran or Veteran’s caregiver receive the emergency contact numbers, including the vendor’s name, current address, and phone numbers? | Yes | | No | |  | |  |
| Did the Veteran or Veteran’s caregiver verbalize understanding of the information provided? | Yes | | No | |  | |  |
| **OXYGEN CONCENTRATOR ONLY** | **ASSESSMENT OR RESPONSE** | | | | | | **REQUIRED FOLLOW-UP** |
| Was the below documented by the Vendor? |  | | | | | |  |
| 1. Does the oxygen concentrator have a sticker with an emergency contact number and vendor name on it? | Yes | | No | |  | |  |
| 1. Is the oxygen concentrator plugged into a grounded outlet? | Yes | | No | |  | | *Describe (e.g., adapter or altered plug).* |
| 1. Does the oxygen concentrator serial number match the DMT? | Yes | | No | |  | | *List serial number:* |
| 1. Is the service date current? | Yes | | No | |  | |  |
| 1. Are the oxygen concentrator hours of use relative to the DMT for estimated use within the timeframe? | Yes | | No | |  | |  |
| 1. Does the alarm work (i.e., can it be heard at least as far as the tubing reaches)? | Yes | | No | |  | |  |
| 1. Does the oxygen concentrator liter flow match the prescription and DMT? | Yes | | No | |  | | *If no, list required actions:* |
| 1. Does the Veteran or Veteran’s caregiver know their prescribed liter flows for sleep, rest, and activity? | Yes | | No | |  | | *Provide detail:* |
| 1. Does the Veteran or Veteran’s caregiver understand that excess O2 can be harmful? | Yes | | No | | N/A | |  |
| 1. Does the Veteran or Veteran’s caregiver understand that a normal response to activity includes an increase in frequency and depth of breathing (i.e., this is not dyspnea or “shortness of breath” (SOB))? | Yes | | No | |  | |  |
| 1. Does the Veteran or Veteran’s caregiver understand that, if there is an increasing occurrence of SOB or SOB that cannot be resolved, they are to call their physician or urgent care? | Yes | | No | |  | |  |
| 1. Does the veteran have appropriate disposable equipment (e.g., tubing, cannulas)? | Yes | | No | |  | |  |
| 1. Does the Veteran or Veteran’s caregiver know how to care for and clean the equipment? | Yes | | No | |  | |  |
| 1. Does the Veteran or Veteran’s caregiver understand the Emergency Back Up Procedure in case of power failure? | Yes | | No | |  | |  |
| **STORAGE OF OXYGEN TANKS, REGULATORS, AND CONSERVERS** | **ASSESSMENT OR RESPONSE** | | | | | | **REQUIRED FOLLOW-UP** |
| Was the below documented by the Vendor? |  | | | | | |  |
| 1. Are O2 tanks stored safely (e.g., lying down in storage rack, chained upright to a wall, in an oxygen transport unit)? | Yes | | No | |  | |  |
| 1. Is the number of O2 tanks on premises compliant with local building or fire codes? | Yes | | No | |  | |  |
| **USAGE OF OXYGEN TANKS, REGULATORS, AND CONSERVERS** | **ASSESSMENT OR RESPONSE** | | | | | | **REQUIRED FOLLOW-UP** |
| Was the below documented by the Vendor? |  | | | | | |  |
| 1. Veteran or Veteran’s caregiver demonstrated how to change tanks. | Yes | | No | |  | |  |
| 1. Veteran or Veteran’s caregiver demonstrated how to change from regulatory to conserver. | Yes | | No | |  | |  |
| 1. Did the Veteran or Veteran’s caregiver verbalize understanding of what a conserver is and does? | Yes | | No | |  | |  |
| 1. Did the Veteran or Veteran’s caregiver verbalize understanding of what flow rate to use for the conserver and why it may be different from the concentrator? | Yes | | No | |  | |  |
| 1. Did the Veteran or Veteran’s caregiver verbalize understanding of how to estimate how much O2 is left and how long it will last? | Yes | | No | |  | |  |
| 1. Did the Veteran or Veteran’s caregiver verbalize understanding of the different sizes of O2 cylinders and capacities? | Yes | | No | |  | |  |
| **VETERAN SATISFACTION WITH VENDOR SERVICE** | **ASSESSMENT OR RESPONSE** | | | | | | **REQUIRED FOLLOW-UP** |
| Were deliveries completed as stated in the contract? | Yes | | No | |  | |  |
| Are vendor employees professional, knowledgeable, and polite? | Yes | | No | |  | |  |
| Did vendor employees instruct Veteran or Veteran’s caregiver on how to use all the devices delivered? | Yes | | No | |  | |  |
| What is the overall satisfaction with the vendor? | Excellent | Good | | Fair | | Poor | *List identified concerns or complaints (if any):* |

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| --- | --- | --- |
| **REVIEW PARTICIPANTS** | | |
| Designated Qualified Individual (Required): | Signature & Date: | Comments: |
| Contracting Officer Representative (Document Review Only): | Signature & Date: | Comments: |
| Home Respiratory Care Team (Document Review Only): | Signature & Date: | Comments: |
| Other (As Required): | Signature & Date: | Comments: |