OXYGEN ORDER FORM

	Medical Card Patient ☐ Yes ☐ No
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:

* Cannula will be included as standard. Please specify in additional information if specific Mask is required.

Concentrator			**Portable oxygen**		
Flow Rate		L/min	Flow Rate		L/min
Hours/day		Or PRN ☐	Hours/day		Or PRN ☐
Bubble Humidifier?	Yes / No		Additional Cylinders Above 6		

Portable Oxygen Concentrator ☐ Caire Comfort Freestyle/ Inogen G3 / Inogen G5

Setting No. 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Caire Freestyle AutoSAT ☐ (Optional)

Sequal Eclipse - Constant flow 0.5 LPM ☐ 1LPM ☐ 2 LPM ☐ 3 LPM ☐

Pulse dose, settings (1-6) ☐

High Rate pulse dose 128ml ☐ 160ml ☐ 192ml ☐

**We recommend a walk test be carried out on this device to ensure appropriate patient saturation*

*** A high Flow concentrator(s) will be required if flows are above 5LPM*

Additional Detail:

Prescriber Information

Print name:

Signed:

Date:

Contact Number:

Bleep Number:

Email Address:

Hospital: Ward:

Please provide prescriber contact information for further clarification if required. Failure to compete the form accurately will cause delays for deliveries to patients home.

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