VA Locations (Check One)
- ❍ Hines (578)
- ❍ Iron Mountain (585)
- ❍ Jesse Brown (537)
- ❍ Madison (607)
- ❍ Milwaukee (695)
- ❍ North Chicago (556)
- ❍ Tomah (676)

VA VISN 12 PMI - HOME SAFETY & EQUIPMENT CHECK FORM

Patient Name: _____ Last Four Numbers of SSN: _____

Prescribed Equipment/Supplies

❍ New Patient Set Up ❍ Existing Patient (check one)

O2 Prescription (LPM): ____ Continuous ____ Rest ____ Exertion ____ Night ____ PRN ____ w/High Humidity Aerosol ____ w/Ventilator

Via: ❍ Nasal Cannula ❍ PAP with sleep ❍ Simple O2 Mask ❍ Trach Mask ❍ Venti Mask ❍ Non-Rebreather Mask

Primary System: ❍ Concentrator ❍ LOX ❍ Cylinders Portable System: Cylinders: ❍ E ❍ D ❍ C (M9) ❍ B (M6) ❍ LOX ❍ POC

VA OCD: ❍ Yes ❍ No Setting Per Prescription: _____ Model: _____ Serial #: _____

Supplies Delivered: ❍ Cannulas ❍ Tubing ❍ Humidifiers ❍ Connectors ❍ Washers ❍ No Smoking Sign ❍ VA Magnet

Fire Safety Valve Issued?: ❍ Yes ❍ No Date Issued: _____

GOAL: *To provide patients/caregivers quarterly continuing education and home/fire safety information associated with the use of home oxygen.*

Equipment Knowledge & General Safety

Smoke Detectors Working	❍ Yes ❍ No	Placement of Equipment is Appropriate for Use	❍ Yes ❍ No
"No Smoking - Oxygen in Use" Signs Posted	❍ Yes ❍ No	Tanks are Stored and Secured Properly	❍ Yes ❍ No
Fire Extinguishers	❍ Yes ❍ No	Sight and Hearing Appropriate for Equipment Use	❍ Yes ❍ No
Emergency Phone Numbers Available	❍ Yes ❍ No	Home Fire Safety Education Performed	❍ Yes ❍ No
Patient Has Obstacle-Free Emergency Exit Route	❍ Yes ❍ No	Patient can Verbalize Oxygen Prescription or Know Where to Find it	❍ Yes ❍ No
Electrical Appropriate for Equipment Use	❍ Yes ❍ No	Patient Instructed on Tubing Change Schedule (Cannulas weekly/Tubing monthly)	❍ Yes ❍ No
Adequate Lighting	❍ Yes ❍ No	Reviewed VA Oxygen Patient Handbooks w/Patient	❍ Yes ❍ No
Patient Can Ambulate Throughout Home Safely	❍ Yes ❍ No	Reviewed Slips/Trips/Falls and Home Safety Pamphlets w/Patient	❍ Yes ❍ No

ITEMS CHECKED "NO" MUST HAVE A CORRESPONDING EXPLANATION IN THE ACTION TAKEN/COMMENTS SECTION

Is the patient a fall risk? (If yes, please explain in Action Taken/Comments section below) .... ❍ Yes ❍ No

Equipment Function

Concentrator Check: _____% at _____LPM ❍ Flow Check Accurate ❍ Alarm ❍ Cabinet Filter Checked

Current Hours: _____ Previous Hours: _____ Total Hours Used: _____

Date of last PMI _____ **Serial Number:** _____

Replace concentrator if at or below 92% or within 3 months of PM hours

Back-Up System in home: ❍ Yes ❍ No **(If "NO" complete AMA)** Size _____ Amount in tank (PSI): _____

******** IF PATIENT IS NOT USING OXYGEN PER PRESCRIPTION, DOCUMENT EDUCATION BELOW *********

Action Taken/Comments: _____

I understand the safety education provided by Total Home Health LLC AND my Rights and Responsibilities (on reverse side) as a recipient of services provided by the VISN 12 outpatient respiratory program. I will refrain from using oxygen while smoking or within 8' of an ignition source.

Staff Name	Date	Patient/Caregiver Signature

Attachment D