

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

VA VISN 12 PMI - HOME SAFETY & EQUIPMENT CHECK FORM

Patient Name: _____ Last Four Numbers of SSN: _____

Prescribed Equipment/Supplies		<input type="radio"/> New Patient Set Up	<input type="radio"/> Existing Patient (check one)
O2 Prescription (LPM): _____ Continuous _____ Rest _____ Exertion _____ Night _____ PRN _____ w/High Humidity Aerosol _____ w/Ventilator			
Via: <input type="radio"/> Nasal Cannula <input type="radio"/> PAP with sleep <input type="radio"/> Simple O2 Mask <input type="radio"/> Trach Mask <input type="radio"/> Venti Mask <input type="radio"/> Non-Rebreather Mask			
Primary System: <input type="radio"/> Concentrator <input type="radio"/> LOX <input type="radio"/> Cylinders		Portable System: Cylinders: <input type="radio"/> E <input type="radio"/> D <input type="radio"/> C (M9) <input type="radio"/> B (M6) <input type="radio"/> LOX <input type="radio"/> POC	
VA OCD: <input type="radio"/> Yes <input type="radio"/> No		Setting Per Prescription: _____ Model: _____ Serial #: _____	
Supplies Delivered: <input type="radio"/> Cannulas <input type="radio"/> Tubing <input type="radio"/> Humidifiers <input type="radio"/> Connectors <input type="radio"/> Washers <input type="radio"/> No Smoking Sign <input type="radio"/> VA Magnet			
Fire Safety Valve Issued?: <input type="radio"/> Yes <input type="radio"/> 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 <input type="radio"/> Yes <input type="radio"/> No	Placement of Equipment is Appropriate for Use <input type="radio"/> Yes <input type="radio"/> No
"No Smoking - Oxygen in Use" Signs Posted <input type="radio"/> Yes <input type="radio"/> No	Tanks are Stored and Secured Properly <input type="radio"/> Yes <input type="radio"/> No
Fire Extinguishers <input type="radio"/> Yes <input type="radio"/> No	Sight and Hearing Appropriate for Equipment Use <input type="radio"/> Yes <input type="radio"/> No
Emergency Phone Numbers Available <input type="radio"/> Yes <input type="radio"/> No	Home Fire Safety Education Performed <input type="radio"/> Yes <input type="radio"/> No
Patient Has Obstacle-Free Emergency Exit Route <input type="radio"/> Yes <input type="radio"/> No	Patient can Verbalize Oxygen Prescription or Know Where to Find it <input type="radio"/> Yes <input type="radio"/> No
Electrical Appropriate for Equipment Use <input type="radio"/> Yes <input type="radio"/> No	Patient Instructed on Tubing Change Schedule (Cannulas weekly/Tubing monthly) .. <input type="radio"/> Yes <input type="radio"/> No
Adequate Lighting <input type="radio"/> Yes <input type="radio"/> No	Reviewed VA Oxygen Patient Handbooks w/Patient <input type="radio"/> Yes <input type="radio"/> No
Patient Can Ambulate Throughout Home Safely <input type="radio"/> Yes <input type="radio"/> No	Reviewed Slips/Trips/Falls and Home Safety Pamphlets w/Patient <input type="radio"/> Yes <input type="radio"/> 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 <input type="radio"/> Flow Check Accurate <input type="radio"/> Alarm <input type="radio"/> Cabinet Filter Checked	
Current Hours: _____ Previous Hours: _____ Total Hours Used: _____	Replace concentrator if at or below 92% or within 3 months of PM hours
Date of last PMI _____ Serial Number: _____	
Back-Up System in home: <input type="radio"/> Yes <input type="radio"/> 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 : _____ 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 _____