Oxygen Questionnaire

Patient		**Date**	

Current Equipment and/or Neb Meds:

Oxygen:_____ Other:_____

1. Are you having any difficulties operating our equipment? No Yes, describe?

2. Are you using your equipment per the doctor's orders? Yes No- Why?

3. Are you changing your disposables supplies (e.g., CPAP masks, tubing, nebulizers, cannulas) as instructed? Yes No-Why?

4. Has your diagnosis changed including re-hospitalizations? No Yes, describe?

5. Has there been a significant change in your condition? No Yes, describe and complete chart below.

Shortness of Breath	Much Worse		Worse		Same		Better	
Cough	Much Worse		Worse		Same		Better	
Mucus Production	Much Worse		Worse		Same		Better	
Activity Level	Much Worse		Worse		Same		Better	
Daytime Sleepiness	Much Worse		Worse		Same		Better	

6. Has there been any significant change to the home environment or support system, or considering going into a facility or hospice care (e.g., caregivers)?

7. Have you had or have you considered changing your insurance coverage?

8. Do you need any supplies sent to you or is there anything else we can do for you?

Additional Comments:

Completed by:		Date	

Additional Follow Up:

None Required		Home Visit by Clinician		Phone Call by Clinical		Other Action Taken	