Paediatric Home Oxygen Record Form

Surname: :..... ***First name: .....*** ***DOB: ..... / ..... ./ .....***

Hospital Number: ..... ***Diagnosis .....***

INFANT- LONG TERM OXYGEN THERAPY (LTOT) ASSESSMENT:

		In prescribed flow rate		
Date	Flow rate required	SaO_2 mean (minimum advised=93%)	Time below 90%* (Should not exceed 5% of recording)	Comments

OTHER INDICATIONS - LONG TERM OXYGEN THERAPY (LTOT) ASSESSMENT:

		In air		In prescribed flow rate		
Date	Flow rate required	Mean SaO_2 awake	Mean SaO_2 asleep	Mean SaO_2 awake	Mean SaO_2 asleep	pCO_2

Additional information

REVIEW / FOLLOW UP – from commencement of oxygen (date): ..... / ..... /.....

Duration on oxygen	Date	O_2 (l/min)	Nasal cannulae / Mask	Hours / day	MeanSaO_2 on O_2	Time (%) * < 90% on O_2	Comments / change to oxygen therapy
1 month							
2 months							
3 months							
4 months							
5 months							
6 months							
7 months							
8 months							
9 months							
10 months							
11 months							
12 months							
18 months							
24 months							
36 months							

*Time < 90% saturation should be expressed as a percentage of the total artefact-free recording time, while on current flow rate.

This form should be kept in the patient records.

This information is for clinical audit purposes, and for confidentiality reasons should not be sent to the oxygen company.