Waitemata
District Health Board
Te Wai Awhina

First Name: ______________________	**Gender:** __________
Surname: ______________________________	
AFFIX PATIENT LABEL HERE	
Date of Birth: ___________________	**NHI#:** _______________
Ward/Clinic:	**Consultant:**

Paediatric Domiciliary oxygen request

PAEDIATRIC DOMICILIARY OXYGEN REQUEST

WDHB Oxygen Service - Ph: (09) 441 8918 (ext) 3918 (int)
Fax: (09)486 8963 (ext) 2463 (int)

Is the patient eligible for public health funding in New Zealand? Yes No (please circle)

Primary Contact- Address: ______________________ Caregiver- name: __________________________________
____ Caregiver- relationship: ______________________________
____ Phone: ____

Alternative contact- Address: __________________ GP name, address, phone (*please complete*) ______________
____ ____
____ ____
Phone: ____________________________________ ____

Primary diagnosis in relation to hypoxia: ____

Brief medical history: ____

Other problems respiratory or non respiratory:
____

Is the patient using CPAP: ____________ or BiPAP: ___________________________

I the patient using oxygen via tracheostomy: ____

Weight (kg): _______________ Nasal prong size: __________________________

Oxygen saturation on room air:_______________% Oxygen sat (on usual flow rate)**:** _______________%

Seen as:

Inpatient ☐ Hospital:______________ Ward / Clinic ___________ Date adm.:_________ Exp. Date disch.: __________

Outpatient ☐ Hospital: ______________ Ward / Clinic ___________

Health Professionals involved **Plan**

Role:	Printed name	Phone/ Locator
Referring doctor		
Primary Paediatrician		
Other paediatrician		
Homecare Nurse		

Discharge Community Oxygen Prescription (*Medical Officer only to complete*)

Patients name ________________________________ NHI ______________________________________

Flow rate _______________________lit/min Usage _________________________h/day

Primary paediatrician – Printed name and Signature____

NZMC Reg No. ____

Could you please add the oxygen service to your distribution list for the discharge summary and subsequent clinic letters for this patient? Thanks Date of referral: ___________________________