AUBURN PHARMACY

Oxygen Quality Assurance Home Visit

Name_____

City/Area_____

Serial Number_____ Hours_____

Set Flow Rate_____ Oxygen Concentration_____

Air Filter Clean? Yes ( ) No ( ) Alarms Working? Yes ( ) No ( )

Portable Checked__ Regulator__ Conserver__ Pressure_____

Extra Cylinders? Yes ( ) No

Number	ID Numbers
A____	_____
B____	_____
C____	_____
D____	_____
E____	_____
H____	_____

Supplies Provided:

Part#	Quantity
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current Physician_____Change? Yes( ) No( )

Current Insurance_____Change? Yes( ) No( )

Equipment Working Satisfactorily? Yes ( ) No ( )
Portable Used this Month? Yes ( ) No ( )
Concentrator Used Each Day? Yes ( ) No ( )

Patient Spo2:_____ Heart rate:_____

Problems/Comments/Inservices:_____
_____
_____
_____

Completed by_____Date_____

Customer Signature_____