

<b>OASIS ITEM:</b>
<p><b>(M0500) Respiratory Treatments</b> utilized at home: <b>(Mark all that apply.)</b></p> <p> <input type="checkbox"/> 1 - Oxygen (intermittent or continuous)  <input type="checkbox"/> 2 - Ventilator (continually or at night)  <input type="checkbox"/> 3 - Continuous positive airway pressure  <input type="checkbox"/> 4 - None of the above </p>
<b>DEFINITION:</b>
Identifies any of the listed respiratory treatments being used by this patient in the home.
<b>TIME POINTS ITEM(S) COMPLETED:</b>
Start of care Resumption of care Discharge from agency – not to inpatient facility
<b>RESPONSE—SPECIFIC INSTRUCTIONS:</b>
<ul style="list-style-type: none"> <li>Excludes any respiratory treatments that are not listed in the item (e.g., does not include nebulizers, inhalers, etc.).</li> </ul>
<b>ASSESSMENT STRATEGIES:</b>
Interview patient/caregiver. Review referral information and medication orders. Observe for presence of such equipment in the home.