EnableNSW

Electrolarynx, Voice Prosthesis and Laryngectomy consumables Equipment Request Form

When to use this form

Use this form if you cannot submit this request using EnableNSW Online.

Find out more at www.enable.health.nsw.gov.au/online

Filling in this form

You can complete this form on your computer, print and sign it. If you need to print this form ensure you:

- Use blue or black pen
- Print in BLOCK LETTERS
- Sign the prescriber declaration

Eligibility

An EnableNSW application form is required to assess a person's eligibility. A new application form is required every two years **OR** if the person's circumstances change. Application forms can be accessed online at www.enable.health.nsw.gov.au/for_individuals/applying-to-EnableNSW. If we do not have an application form at the time of reviewing this request, the request may go on hold and delay the outcome.

Important information before making this request

- You must be an eligible prescriber for this type of equipment **AND**,
- the equipment requested must meet the applicable funding criteria. You can read more about this at www.enable.health.nsw.gov.au/prescribers/forms

For more information

Go to our website www.enable.health.nsw.gov.au or call us on 1800 Enable (1800 362 253)

Privacy

We collect your personal information and the health information of patients to allow EnableNSW to manage and provide its services. This allows us to:

- Assess your eligibility to prescribe assistive technology in accordance with the relevant funding criteria
- Contact you if more clinical information is required about the request, as well as provide status updates about the request
- Share contact details with a supplier if additional support is required for set up of equipment when necessary.

If you would like to view or make changes to your information, please send an email to enable@health.nsw.gov.au or call 1800 Enable (1800 362 253).

A. Request type

☑ New request ☐ Amendment to existing request

For new requests - provide date of surgery D D/M M/Y Y Y Y AND date of discharge D D/M M/Y Y Y Y

B. Person information

1. Person details

Title _____ First name _____ Surname _____

Date of birth D D/M M/Y Y Y Y

Medicare card number ☐☐☐☐ ☐☐☐☐☐ ☐ Ref no. ☐

Person's address _____

_____ State Postcode

2. Delivery details

Where will the equipment be delivered to? *Select ONE only*

☐ Person's address ***Go to question 3***

☐ Other, please specify where the equipment will be delivered _____

Contact name _____ Contact phone number ( )

Delivery address _____

(if not person's address) _____ State Postcode

C. Diagnosis

3. What is the primary diagnosis and clinical information in relation to the requested equipment?

4. Provide other relevant diagnosis/co-morbidities

D. Equipment specification and justification: standard voice equipment

5. Select type of standard voice equipment requested and add product details in table: *Select ONE option only*

Standard voice equipment	Request type	Product Details	Product code	Supply allocation
☐ Electrolarynx	☐ New ☐ Replacement	Name Manufacturer		☐ *One only**
OR				
☐ Indwelling voice prosthesis	☐ New ☐ Replacement	Name Manufacturer		☐ *Standard: 3/year* ☐ *Higher allocation: 4/year*
OR				
☐ Non-indwelling voice prosthesis	☐ New ☐ Replacement	Name Manufacturer		☐ *6/year*

*Equipment marked as one only will be replaced at the end of an item's workable life or expiry date and a request is received from the person's prescriber.

☐ N/A-Standard voice equipment is not being requested or changed

6. If Electrolarynx is selected above - confirm the following:

☐ The person requires an electrolarynx for primary communication and has successfully trialled the equipment

OR

☐ N/A-Electrolarynx equipment is not being requested or changed

7. If ANY voice prosthesis selected above - confirm ALL of the following:

☐ The trache-oesophageal fistula is stable post surgery

☐ The voice prosthesis is required for long-term use by the person for primary communication

☐ The prescribed voice prosthesis product and size is stable and likely to be required long-term

OR

☐ N/A-Voice prosthesis equipment is not being requested or changed

8. If ANY voice prosthesis HIGHER ALLOCATION is selected above, complete section below. *Select all that apply*

Confirm the following statement, select one or more reasons and provide additional information below.

☐ The person consistently requires more frequent replacement of their voice prosthesis despite medical optimisation, due to (please select one or more reasons):

- ☐ Early voice prosthesis failure
- ☐ Voice prosthesis insufficiency (e.g. swallowing dysfunction)
- ☐ Accidental dislodgement
- ☐ Voice prosthesis needing to be removed e.g. presence of granulation tissue, surgery
- ☐ Trache-oesophageal puncture dysfunction

OR

☐ N/A-Higher allocation of voice prosthesis is not being requested

E. Equipment specification and justification: non-standard voice equipment

9. If a tracheostoma/hands free speech valve starter kit is being requested, complete the table and confirm ALL of the following:

Standard voice equipment	Request type	Product Details	Product code	Supply allocation
☐ Tracheostoma/ hands free speech valve starter kit	☐ New ☐ Replacement	Name Manufacturer		*One only**

*Equipment marked as one only will be replaced at the end of an item's workable life or expiry date and a request is received from the person's prescriber.

☐ The person has demonstrated compliant use of the prescribed HME equipment **AND**

☐ The person has the required dexterity and cognitive ability to manage a hands-free speech valve **AND**

☐ The person is motivated to use hands free speech due to self care needs

Provide details of the relevant self care needs that the tracheostoma/hands free speech valve starter kit would be useful for

OR

☐ N/A-Tracheostoma/hands free speech valve starter kit is not required

F. Equipment specification and justification: heat moisture exchangers (HMEs) and stoma covers

10. Select type of HMEs or stoma covers, and add product details in table:

HMEs and stoma covers	Request type	Product Details	Product code	Supply allocation *(Note: HME single option or combination up to 730/yr)*
☐ HME option 1	☐ New ☐ Replacement	Name Manufacturer		/year
☐ HME option 2	☐ New ☐ Replacement	Name Manufacturer		/year
☐ HME option 3	☐ New ☐ Replacement	Name Manufacturer		/year
OR				
☐ Foam stoma cover/protector-adhesive type	☐ New ☐ Replacement	Name Manufacturer		*365/year*
OR				
☐ Foam stoma cover/protector-Reusable non-adhesive type (humidification/ filtration)	☐ New ☐ Replacement	Name Manufacturer		*120/year*

☐ N/A -HMEs/stoma covers are not being requested or changed

G. Equipment specification and justification: adhesive seals/baseplates

11. Select type of adhesive seals/baseplates, and add products details in table:

Adhesive seals / baseplates	Request type	Product Details	Product code	Supply allocation *(Up to 365/yr)*
☐ *Standard adhesive seal* ☐ *Non-standard adhesive seal*	☐ New ☐ Replacement	Name Manufacturer		

☐ N/A - Adhesive Seals/Baseplates are not being requested or changed

12. If non-standard adhesive seals are requested - confirm reason for requiring non-standard adhesive seal (select one or more), AND provide any additional justification below

☐ The person has trialled a standard adhesive seal for at least 2 weeks and due to poor seal or dexterity is unable to safely use the standard adhesive seal

☐ The person uses a hands-free system

☐ The person requires a non-standard adhesive seal for anatomical reasons (e.g. deep stoma or complex neck/stoma anatomy post surgery)

OR

☐ N/A-Non-standard adhesive seals are not being requested or changed

H. Equipment specification and justification: laryngectomy respiratory consumables

13. Select all additional laryngectomy respiratory consumables being requested and add product details in table:

Laryngectomy respiratory consumables	Request type	Product Details	Product code	Supply allocation
☐ Tracheostoma buttons	☐ New ☐ Replacement	Name Manufacturer		*2/year*
OR				
☐ Laryngectomy tubes	☐ New ☐ Replacement	Name Manufacturer		*2/year*
AND any relevant combination of the following can be selected:				
☐ Securing devices: Neck straps	☐ New ☐ Replacement	Name Manufacturer		*52/year*
☐ Voice prosthesis cleaning brush	☐ New ☐ Replacement	Name Manufacturer		*12/year*
☐ Laryngectomy tube cleaning brush	☐ New ☐ Replacement	Name Manufacturer		*12/year*
☐ Plug insert for voice prostheses	☐ New ☐ Replacement	Name Manufacturer		*One only**
☐ Dilator	☐ New ☐ Replacement	Name Manufacturer		*One only**
☐ Voice Prosthesis flushing device	☐ New ☐ Replacement	Name Manufacturer		*One only**

☐ Gel cap insertion system	☐ New ☐ Replacement	Name Manufacturer		*One only**
☐ Gel caps	☐ New ☐ Replacement	Name Manufacturer		*One only**

*Equipment marked as one only will be replaced at the end of an item's workable life or expiry date and a request is received from the person's prescriber.

☐ N/A - Laryngectomy respiratory consumables are not being requested or changed

14. If gel caps or gel cap insertion kit is selected, confirm the following

☐ The person is independently changing their voice prosthesis out of the clinical setting

☐ N/A – Gel caps or gel cap insertion kits are not being requested

I. Eligibility: electrolarynx, voice prosthesis and laryngectomy consumables

15. Electrolarynx, voice prosthesis and laryngectomy consumables - Confirm ALL of the following have been addressed for every request:

☐ A minimum two (2) week trial of the prescribed equipment/consumables has been completed

☐ The prescribed equipment/consumables are required for long term use (>12 months)

☐ The most clinically appropriate, cost-effective option has been considered

☐ The prescriber has provided the appropriate education to the person regarding correct use, care and maintenance of equipment in order to prolong device life and to minimise product wastage

☐ The person/carer is aware that there are supply allocations through EnableNSW and how they can purchase additional supplies if required

J. Ongoing monitoring and assessment

16. Provide the details of the eligible clinician/prescriber who will continue to monitor the person's condition:

☐ The prescriber for this request will assess and monitor the person's condition

☐ A different eligible prescriber will assess and monitor the person's condition. Provide name, qualification, phone number, email address and clinical service in the text box below

Go to next page and complete Section K. Prescriber eligibility and declaration

K. Prescriber eligibility and declaration

17. Prescriber eligibility

Confirm you have assessed the person and have the qualification and level of experience to prescribe this equipment in line with the relevant EnableNSW Funding Criteria and Professional Criteria for Prescribers.

☐ Yes ***Go to question 18***

☐ No – I do not have the level of experience to prescribe this type of equipment as required by the funding criteria.

The assessment of the person and equipment request has been supervised by an eligible EnableNSW prescriber. Provide your supervisor's name and email address

Supervisor's name | Supervisor's email

18. Prescriber declaration

I confirm the following:

- The person/carer agrees with this request
- A copy of this request will be provided to the person/carer
- As a health professional, I cannot also be the equipment supplier for the same request. This may include but is not limited to a personal or professional relationship with or material interest in the supplier or manufacturer of the equipment listed on this request

I declare that:

- I have the qualification and experience to prescribe this equipment or, I have been supervised by an eligible EnableNSW prescriber for this type of equipment
- All information I have supplied on this application is true and correct to the best of my knowledge at the time of assessment

Prescriber information:

Prescriber name

Place of work

Address

State Postcode

Qualification | AHPRA registration number

Phone number ( ) | Email

Signature | Date D D/M M/Y Y Y Y

19. Other contacts (optional)

Complete this question if you would like to provide details of any other relevant health professionals who will be involved with the management and monitoring of the person's condition

Other contact 1

Name

Place of work

Address

State Postcode

Qualification | AHPRA registration number

Phone number ( ) | Email

Other contact 2

Name

Place of work

Address

State Postcode

Qualification | AHPRA registration number

Phone number ( ) | Email

Submitting this request

Submit this form and any relevant clinical documentation to enable@health.nsw.gov.au, please include the following in your subject line **Equipment type_Person name_Date submitted** *i.e Voice Prosthesis _ John Smith_01.01.2022*