EnableNSW

Oxygen - Adult & Paediatric Annual Review, Change of Script and Cessation 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 or 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).

Registering the device with the person's electricity provider
As part of the person's emergency plan, please ensure they have contacted their electricity provider and registered details about their life support medical device. This should ensure the person receives adequate support during power outages. Additionally, the rebate form through Service NSW can be completed to assist with the cost of living www.service.nsw.gov.au/transaction/apply-for-the-life-support-energy-rebate-retail-customers

A. 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 option*

☐ 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 ☐

B. Script type

3. Select ONE option below:

Note: The relevant LTOT form (Adult or Paediatric) should be completed if requesting an oxygen concentrator or cylinder oxygen which has not been previously approved.

☐ **Annual oxygen re-application (12 month review)**

If selected, please complete the following:

☐ The person's condition continues to be stable and requires long term oxygen therapy at home

OR

☐ **Change of prescription (including change in oxygen concentrator specifications) since initial long term oxygen therapy (LTOT) approval**

☐ The person's oxygen flow rate has changed but remains within the specifications of the current stationary oxygen concentrator.

OR

☐ The person's oxygen flow rate has changed and they will require a stationary oxygen concentrator with lower flow rate specifications (and assessed to be effective and safe).

OR

☐ The person's flow rate has changed and they will require an oxygen concentrator with higher flow rate specifications (e.g. currently using a standard concentrator and flow rates have increased to 6L/min or higher).

If selected, provide clinical context, and how increased flow rate was assessed / determined and deemed to be safe for the person and community use:

OR

☐ **Oxygen rental equipment no longer required**

If selected, complete the following:

☐ The person / family has been contacted by the clinical service to discuss cessation of oxygen funding

AND

Provide relevant information:

Proceed to Section G. Prescriber eligibility and declaration

C. Oxygen requirement and equipment specification

4. The consumer's current oxygen requirement is:

☐ ≥ 16 hours/day

☐ ≥ 6 hours/day (nocturnal hypoxaemia)

5. **Select one oxygen stationary concentrator and specify flow rate:** *Select ONE option*

- ☐ Oxygen concentrator standard flow (0 - 5 L/min). Flow rate (L/min) ____
- ☐ Oxygen concentrator high flow (6 – 10 L/min). Flow rate (L/min) ____
- ☐ Paediatric oxygen concentrator 0 – 1 L/min with 0.1 L/min increments (BOC areas)* Flow rate (L/min) ____
- ☐ Paediatric oxygen concentrator 0 – 2 L/min with 0.125 L/min increments (Supagas areas)* Flow rate (L/min) ____
- ☐ No oxygen concentrator requested ____

*Paediatric oxygen concentrator specifications vary. Please check with your supplier and provide a compatible flow rate

6. **Select C size cylinders and specify flow rate:** *Select ONE option*

- ☐ Portable oxygen C cylinders x2 with standard regulator x1. Flow rate (L/min) ____
- ☐ Portable oxygen C cylinders x2 with conserver regulator x1. Flow rate (L/min) ____
- ☐ No portable cylinders requested

7. **Does the person use continuous oxygen (≥ 16 hours/day) AND reside > 2 hours from their closest hospital?**

- ☐ No
- ☐ Yes – provide D Cylinder. Flow rate (L/min) ____

D. Stability, compliance and ongoing follow-up

8. **Confirm ALL of the following have been addressed:**

- ☐ The person/parents/guardians is/are aware that they will not be eligible for funding if they smoke
- ☐ Recommended oxygen equipment is compatible with the person's living environment
- ☐ The person/parents/guardians is/are aware that data regarding oxygen therapy usage will be collected by the supplier and can be obtained by the prescriber and EnableNSW.
- ☐ Annual review scheduled for people who remain on community oxygen

E. Community safety, training and emergency plan

9. **Confirm ALL of the following three criteria demonstrating adequate community safety, carer training and provision of an emergency plan have been addressed:**

- ☐ A risk assessment has been conducted and documented, and the person can be safely managed on the prescribed equipment in the community
- ☐ The person and family/carer/s have received adequate training, and have acknowledged the risks and responsibility for safely managing the person and the equipment in the community
- ☐ An individual care plan and an emergency plan have been documented and communicated to the person and their family/carer/s, to manage clinical and equipment emergencies and to allow the person to live safely in the community

F. Ongoing monitoring and assessment

10. Provide the details of the eligible clinician/prescriber who will continue to monitor the person: *Select ONE option*

☐ The prescriber for this request (Respiratory/Palliative Care Physician) will assess and monitor the person's condition

☐ A different eligible prescriber (Respiratory/Palliative Care Physician) will assess and monitor the person's condition

Provide name, qualification, phone number, email address and clinical service:

☐ *For adult applications only:* An eligible Nurse Practitioner will assess and monitor the persons condition, working in collaboration with a Respiratory or Palliative Care Physician.

Provide name, qualification, phone number, email address and clinical service, and name of the Respiratory or Palliative Care Physician:

☐ *For adult applications only:* Requests from other prescribers, such as general practitioners or physicians, will only be considered in rural or remote areas, where an eligible prescriber (Respiratory Physician, Palliative Care Physician or Respiratory Nurse Practitioner) is unavailable within the health service/ Local Health District.

If this is the case, with each application the prescriber must provide a letter:

☐ Outlining the reasons why an eligible prescriber is not available **AND**

Provide name, qualification, phone number, email address of the clinician responsible for follow-up and ongoing respiratory care of the person:

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

G. Prescriber eligibility and declaration

11. 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

12. 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

13. 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 Oxygen_Annual review_request_John Smith_01.01.2022*