EnableNSW
Continuous Ventilation 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
- Full technical and physician reports of all relevant tests, and complete script/s must be submitted with this request.

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

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 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

C. Diagnosis and clinical letter

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

4. Provide other relevant diagnosis/co-morbidities

5. Clinical letter from Respiratory/Sleep Physician - confirm ALL of the below have been addressed in the attached letter:

- ☐ Primary cause of respiratory failure and other relevant comorbidities or history
- ☐ Confirmation that the person's requirement for continuous/life support ventilation equipment in the community has been assessed during a period of clinical stability i.e. not during or immediately recovering from an acute illness
- ☐ Who will be responsible for ongoing clinical review of the person's long-term ventilation requirements

D. Equipment category

6. Select the standard continuous/life support ventilator device being requested: *Select ONE option*

Please note: This includes 2 x TGA community appropriate life support ventilators with internal and external batteries with standard accessories (1 x in-use/mobility bag per device and standard air inlet filters)

- ☐ Philips Trilogy EVO
- ☐ ResMed Astral 150

7. For people using mouthpiece ventilation (MPV) - Select MPV support kit/arm system: *Select ONE option*
(Please note: Use the ventilator circuit and accessories equipment request form if MPV circuits are being requested)

- ☐ MPV not required
- ☐ Philips MPV Support System Kit
- ☐ ResMed Mouthpiece Ventilation Circuit Support Arm

8. Are any external humidifiers, test lungs, manual resuscitators, ventilator circuits or other ventilation consumables being requested? *Select ONE option*

People who meet the criteria for continuous (life support) ventilators are eligible for humidifiers, test lungs, manual resuscitators, ventilator circuits and certain other ventilation consumables.

- ☐ Yes, my patient requires this equipment and consumables and I will be completing the relevant equipment request forms to apply
- ☐ No, my patient does not require this equipment or consumables

E. Indication for continuous/ life support ventilation equipment

9. Select the indication for continuous/ life support ventilation equipment: *Select ONE option*

- ☐ Adult - Continuous Ventilation
- ☐ Paediatric - Continuous Ventilation

F. Demonstration of requirement for continuous/life support ventilation equipment

10. Confirm one of the following for demonstration of requirement for continuous ventilation equipment:

- ☐ The person has respiratory insufficiency which has resulted in the need for respiratory support for ≥ 16 hours per day, with significant periods of awake time on ventilation, and where no further weaning of daytime ventilation is indicated or possible
- ☐ *Adult only (if does not meet above criteria)*: Repeated attempts to reduce the time on daytime/awake ventilatory support (for periods <1hr) have resulted in acute respiratory compromise with a rise in carbon dioxide (CO_2) ≥ 8mmHg from baseline on paired arterial or arterialised earlobe capillary blood gases, end-tidal CO_2 monitoring or transcutaneous CO_2 monitoring when off ventilatory support

G. Demonstration of stability and usage on the prescribed equipment

11. Confirm ALL of the below and attach relevant documentation for demonstration of stability and usage on the prescribed continuous/life support ventilation equipment:

- ☐ Ventilation titration polysomnogram (PSG) OR overnight oximetry (+/-CO_2 trend) + detailed polygraphic data demonstrates adequate control of gas exchange on prescribed ventilation mode and settings
- ☐ The person has trialled the prescribed community appropriate life support ventilator and associated accessories/ consumables for at least one week, and the equipment is suitable for the person's ongoing use in the community
- ☐ Compliance download demonstrates usage of the prescribed community appropriate life support ventilator ≥ 16 hrs/day over a 1-2 week period. Attach download and provide average hours of usage per day (hours:min): _____

H. Community safety, carer training and emergency plan

12. 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.

I. Continuous ventilation device settings

13. Attach complete script for continuous ventilation device settings, signed and dated by a Respiratory or Sleep Physician: *Select ONE option*

Script must include name and date of birth of the person, script date (a current date is required), ventilator mode & complete settings, alarm settings, clearly labelled individual scripts if dual/multiple programs are prescribed. Proforma scripts can be accessed on the EnableNSW website: www.enable.health.nsw.gov.au/prescribers/forms/home-respiratory-program-hrp/scripts

- ☐ Script using template for Philips Trilogy EVO provided
- ☐ Script using template for ResMed Astral 150 provided

14. Primary interface: *Select ONE option*

- ☐ Full face mask
- ☐ Nasal pillows
- ☐ Tracheostomy
- ☐ Nasal mask
- ☐ Oral mask

15. Secondary interface: *Select ONE option*

- ☐ N/A
- ☐ Nasal mask
- ☐ Oral mask
- ☐ Full face mask
- ☐ Nasal pillows
- ☐ Mouthpiece

16. Is supplemental oxygen entrained into the system? *Select ONE option*

- ☐ No
- ☐ Yes - provide oxygen flow rate (L/min) _____

J. Urgent repairs and routine servicing contacts

17. Provide confirmation that the prescriber agrees to provide a new script with current settings, current date, and physician signature in a timely fashion when requested: *Select ONE option*

☐ Yes - the prescriber (Sleep/Respiratory Physician) for this request is the preferred primary contact for up-to-date scripts

☐ Yes - a different prescriber (Sleep/Respiratory Physician) should be contacted for up-to-date scripts. If selected, provide contact details for the alternative prescriber:

18. ALL applications are required to provide one or more alternate monitored Clinical Service contact/s to obtain up-to-date ventilator scripts to support emergency ventilator repairs in the community. Provide details including email and phone number in the text box below:

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

K. Prescriber eligibility and declaration

19. 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

20. 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

21. 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 Continuous_Ventilation_equipment_John Smith_01.01.2022*