EnableNSW
Heated humidifiers (Invasive and 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

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

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

4. Provide other relevant diagnosis/co-morbidities

D. Equipment category

5. Indicate the heated humidifier model being requested: *Select ONE option*

- ☐ Fisher and Paykel 950ANZ with sensor cartridge (use in invasive and mask ventilation)

  If selected, provide expiratory limb heater wire option: *Select ONE option*

  - ☐ Single inspiratory limb circuit will be used (no Expiratory Limb Heater Wire Adaptor required)
  - ☐ Dual limb (inspiratory and expiratory) circuit will be used and expiratory limb requires heating (requires Expiratory Heater Wire Adaptor-950X00)

- ☐ Fisher and Paykel MR810 (use in mask ventilation)

6. For all requests: Are ventilator circuits and/or water bags (specific to the requested humidifier) being requested? *Select ONE option*

- ☐ Yes - ventilator circuits and/or water bags are required for the requested humidifier and I will be completing a Ventilator Circuits and Accessories Equipment Request Form
- ☐ No - ventilator circuits and/or water bags are not being requested

E. Equipment justification: heated humidifiers

7. What is the indication for the requested humidifier equipment? *Select ONE option*

- ☐ Continuous / life support ventilation (≥16 hours per day) - *Two identical humidifiers will be provided*
- ☐ Nocturnal invasive (tracheostomy) ventilation (≥ 6hrs/night) - *One humidifier will be provided*
- ☐ A child using a device that does not support an integrated humidifier, for nocturnal or < 16 hours per day - *One humidifier will be provided*

F. Equipment trial, carer training/competency and safety

8. Confirm ALL of the following:

- ☐ A trial has been completed in conjunction with the ventilator trial
- ☐ The person/carer has received training and is competent in the use of the equipment
- ☐ 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.

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

G. Prescriber eligibility and declaration

9. 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

10. 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

11. 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 Heated Humidifiers_equipment_John Smith_01.01.2022*