EnableNSW

Mechanical In-Exsufflation 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
- Ensure compliance report and complete script is 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 ☐ Amendment to existing 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 in relation to the requested equipment?

4. Provide other relevant diagnosis/co-morbidities:

5. Select age and diagnostic group for this application: *Select ONE option*

- ☐ People ≥ 12 years of age-Neuromuscular, neurodegenerative or neurological respiratory weakness / disorder
- ☐ People ≥ 12 years of age-Spinal cord, brainstem or brain injury
- ☐ Children < 12 years of age-Neuromuscular, neurodegenerative or neurological respiratory weakness / disorder
- ☐ Children < 12 years of age-Spinal cord, brainstem or brain injury

D. Equipment category: MIE and related consumables selection

6. Select MIE device requested:

- ☐ N/A -MIE device not being requested
- ☐ Breas NIPPY Clearway 2 (includes power cord, internal battery, SD card, carry bag and air inlet filter)

7. Select MIE circuit size/type requested: *Select ONE option*

- ☐ N/A-Consumables are not being requested
- ☐ Circuit kit (includes 6 FT tubing, interface and bacterial filter) (Annual allocation = 6 / year). *If selected, choose one size:*
  - ☐ Trache
  - ☐ Infant
  - ☐ Toddler
  - ☐ Adult Small
  - ☐ Adult Medium
  - ☐ Adult Large
  - ☐ Mouthpiece
- ☐ Alternative circuit: Reusable tubing (x 3/year), mask connector (x 2/year) and mask for MIE use (×2/year).
  If selected, check EnableNSW Online catalogue for options and provide details:

8. Select additional items requested: *Select all that apply*

- ☐ N/A-additionalitems are not being requested
- ☐ 50 additional bacterial filters (342077 or equivalent) (per year)
- ☐ External manual remote hand control switch (2210.2563) - A trial of a hand control switch to demonstrate that it is required and will be used

E. Baseline measures

9. Select one or more of the following baseline measures: *Select all that apply*

- ☐ Unassisted Peak Cough Flow less than 270L/min. Provide measure (L/min):
- ☐ 24 hour/day continuous ventilation

OR additional baseline measure options for children < 12 years old: *Select all that apply*

- ☐ Two admissions with chest infection per year
- ☐ Prolonged treatment times/ fatigue during airway clearance without MIE
- ☐ Ineffective cough based on clinical observation with inability to independently clear sputum

F. Peak cough flow improvement

10. Select one or more of the following improvement measures: *Select all that apply*

☐ Peak Cough Flow >160L/min during exsufflation on prescribed pressures.

Provide measure (L/min): _____

OR additional peak cough flow improvement options for children < 12 years old: *Select all that apply*

- ☐ Reduction in respiratory infections/admissions
- ☐ Reduced frequency of tracheal suctioning
- ☐ Reduced treatment times/ fatigue during airway clearance
- ☐ Improved sputum clearance (compared to without MIE)

G. Pre and post questionnaires

11. Attach the completed MIE pre questionaire and confirm ALL of the following

☐ MIE pre questionnaire is completed and attached

☐ MIE user / carer agrees to be contacted by EnableNSW after 6 months of receiving their MIE device to complete a MIE post-questionnaire

H. MIE Home trial and compliance download

Provide evidence of MIE home trial and compliance download

12. Confirm the following AND attach a download report of 14 consecutive days. *(Download report must be <4 months old).*

☐ Download demonstrates usage of MIE for ≥ 70% of days: Provide % of days used _____

I. MIE script

Script templates can be found on the EnableNSW Home Respiratory Program website www.enable.health.nsw.gov.au/prescribers/forms/home-respiratory-program-hrp/scripts . Must be signed by a Physiotherapist who is an eligible MIE prescriber as per funding criteria.

13. Attach MIE script using the device specific template: *Select ONE option*

☐ N/A application is for MIE consumables

☐ Script with full MIE settings attached

J. Follow-up

14. Confirm ALL of the following and provide alternative follow-up details if applicable: *Select all that apply*

☐ The person requires long term (> 3 months) use of mechanical in-exsufflation in the community.

☐ Ongoing clinical follow-up has been arranged.

☐ Optional: If the person is being followed up by a different clinical service or prescriber, provide contact details of the clinical service for future reviews or updated settings for repairs and maintenance.

K. Clinical considerations and responsibilities

15. Confirm ALL of the following have been addressed: *Select all that apply*

☐ Clinical team has considered the person's medical and social history and contraindications/precautions of mechanical in-exsufflation therapy. Potential risks have been discussed with the person/ and their family/carer, and they have given informed consent.

☐ A plan has been discussed and provided to the person and their family/carer to manage clinical and equipment emergencies.

☐ Clinical team has educated the person and their family / carer how to use the device, the rationale for its use and when to use it. A treatment plan should be provided to the person including the frequency, repetitions and duration of insufflation and when to perform exsufflation.

☐ The person has been provided with contact details of the clinical service.

L. Responsibilities of the person/carer

16. Regarding responsibilities of the person/carer, confirm ALL of the following have been addressed: *Select all that apply*

- ☐ The person is aware that funding for all other accessories (e.g. air inlet filters, alternative face masks, etc.) or consumables above the annual allocation will be their responsibility.
- ☐ The person/ their family/carer is able to use the recommended equipment safely and appropriately, including care, maintenance and emergency planning in the event of equipment failure.
- ☐ The person is able to tolerate and willing to use mechanical in-exsufflation on a daily basis.

M. Consumables first order placement and delivery location

17. Would you like EnableNSW to place the first order of MIE consumables of this request on behalf of the person? *Select ONE option*

- ☐ No
- ☐ Yes - 3 month supply
- ☐ Yes - 6 month supply

If Yes selected above, indicate the delivery location of MIE consumables: *Select ONE option*

- ☐ Person's home address
- ☐ Same address as MIE equipment (specified in Question 2)

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

N. Prescriber eligibility and declaration

18. 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 19***

☐ 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

19. 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

20. 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 MIE_John Smith_01.01.2022*