

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

B. Person Information

1. Person details

Title First name Surname

Date of birth

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

D. Suction units and suction catheters: equipment recommendation

5. Are you requesting a suction unit? *Select ONE option*

- No-Requesting suction catheters only
- Yes-Standard suction unit (1 x Laerdal: LSU 78000033; includes 12x Filters, 3x Tubing & Battery)
- Yes-Non-standard suction unit x 1 (e.g. suction unit designed for frequent/high suction, high flow applications)
- Yes-The person also being continuously ventilated (>16 hours per day) *If selected, choose ONE option:*
 - Two standard suction units will be provided (Laerdal: LSU 78000033; includes 12x Filters, 3x Tubing & Battery) **OR**
 - One standard suction unit (LSU 78000033) and one non-standard suction unit will be provided

If a non-standard suction unit is selected in any option above:

Provide device details from the EnableNSW catalogue:

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Provide clinical rationale and justification:

6. Are you requesting suction catheters? *Select ONE option and provide details as required*

- No-Suction catheters are not being requested
- Yes-Y suction catheters (2160 / year). Standard contract suction catheters of the following size will be supplied.

Size (FG):

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Alternatively, if a specific Y suction catheter is required:

Provide product name:

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Provide manufacturer's details and product code:

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Provide clinical rationale and justification:

- Yes-Closed suction catheters (120 / year). Standard contract suction catheters of the following size will be supplied.

Size (FG):

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Alternatively, if a specific closed suction catheter is required:

Provide product name:

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Provide manufacturer's details and product code:

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- Yes-Split allocation of two or more different suction catheters-provide product name and manufacturer's product code and size for each type of catheter being requested. Also please specify the allocation ratio (e.g. 50:50 split). *(If catheter size and type is only provided, standard contract catheters will be issued).*

E. Suction units and suction catheters: patient selection and requirements

7. **Select patient/airway category:** *Select one option and ensure the relevant supporting documentation is completed and attached*

- Non-bypassed airway-Provide a 2-week log from a trial on the equipment, documenting the reason for each suction episode, and the number of suction episodes per day (including date and time)
- Bypassed airway (e.g. tracheostomy; long term nasopharyngeal airway for paediatric patients) - *Suction log not required*

F. Equipment justification and safety

8. **Confirm ALL of the following:**

- The person is unable to maintain their airway and independently clear secretions
- The person is stable in the community setting and requires the equipment on a regular basis (not for emergency or episodic use)
- The person / carers have been using a suction unit and received the necessary training in using the prescribed 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

G. Consumables first order placement and delivery location

9. **Would you like EnableNSW to place the first order of suction catheters of this request on behalf of the person?** *Select ONE option*

- No
- Yes-3 month's supply
- Yes-6 month's supply

If Yes selected above, indicate the delivery location of suction catheters. *Select ONE option*

- Person's home address
- Same address as suction unit equipment (specified in Question 2)

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

H. Prescriber eligibility and declaration

10. 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

11. 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	<input type="text"/>		
Place of work	<input type="text"/>		
Address	<input type="text"/>		
	<input type="text"/>	State	Postcode
Qualification	<input type="text"/>	AHPRA registration number	<input type="text"/>
Phone number	(<input type="text"/>) <input type="text"/>	Email	<input type="text"/>
Signature	<input type="text"/>	Date	<input type="text" value="D D/M M/YYYY"/>

12. 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	<input type="text"/>		
Place of work	<input type="text"/>		
Address	<input type="text"/>		
	<input type="text"/>	State	Postcode
Qualification	<input type="text"/>	AHPRA registration number	<input type="text"/>
Phone number	(<input type="text"/>) <input type="text"/>	Email	<input type="text"/>

Other contact 2

Name	<input type="text"/>		
Place of work	<input type="text"/>		
Address	<input type="text"/>		
	<input type="text"/>	State	Postcode
Qualification	<input type="text"/>	AHPRA registration number	<input type="text"/>
Phone number	(<input type="text"/>) <input type="text"/>	Email	<input type="text"/>

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 *Suction Unit and Suction Catheters_John Smith_01.01.2022*