Home Enteral Nutrition Equipment Request Form

Refer to Funding Criteria for information regarding eligible persons, eligible prescribers and equipment provided. Please ensure all details are correct and a completed Consumer Application Form is also submitted.

☐ **New Request** ☐ **Amendment to Existing Request**

1. PERSON'S INFORMATION

Last Name	**First Name**
Title ☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Other	**Date of Birth**
Address	**Suburb** **Post Code**
Email	
Phone	**Mobile**
Contact Person	**Relationship** ☐ Partner ☐ Parent ☐ Carer ☐ Friend
Email	**Phone** **Mobile**

☐ Tick if the applicant would prefer their Contact Person to be first point of contact for EnableNSW

Primary Diagnosis	**Secondary diagnoses**

2. IDENTIFICATION OF NEED- GOALS

HEN is required for:

☐ Complete nutrition and/or hydration
☐ Supplemental nutrition and/or hydration
☐ Other, please describe

3. EQUIPMENT JUSTIFICATION

a. Date of assessment:
b. When did the person commence tube feeding? Date:
c. Will the person require HEN for 12 months or longer? ☐ Yes ☐ No
d. For nasogastric (NG) tube requests:
  - Has NG tube feeding been established for 6 months or more? ☐ Yes ☐ No
  - Please provide clinical reasons for NG tube, including why gastrostomy tube is not suitable:

Please confirm the following:

☐ Person/carer is aware that there are supply allocations through EnableNSW and how they can purchase additional supplies if required.
☐ Person/carer has received training and written instructions on use and care of the equipment

4. EQUIPMENT RECOMMENDATION

Please indicate the method of tube feeding:

☐ Gastrostomy tube
☐ Nasogastric tube
☐ Other:

Please select HEN regimen/recommendations:

☐ Continuous via a pump
☐ Intermittent via a pump
☐ Bolus via a pump
☐ Gravity via a giving set
☐ Bolus via a syringe/dispenser

Do any of the items requested below replace existing products? ☐ No ☐ Yes
If yes, please provide details of the previous products

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HealthShare EnableNSW

New Product	Replacement Product	Product Name	Code	Supplier	Standard Allocation	Non-Standard Allocation*
☐	☐	Gastrostomy tube			☐ 3/year	
		OR				
		Nasogastric tube			☐ 10/year	
		OR				
		Decompression tube			☐ 10/year	
☐	☐	Extension tubes			☐ 10/year	
☐	☐	Standard giving set			☐ 270/year	
		OR				
		Non-standard giving set			☐ 150/year	
☐	☐	Containers			☐ 50/year	
☐	☐	Reusable Bolus/Water Flush Syringe				
		☐ 50/60 mL			☐ 100/year	
		OR				
		☐ 60 mL ENFit			☐ 52/year	
☐	☐	Reusable Water Flush Syringe/Dispenser				
		☐ 10 mL **OR** ☐ 20 mL			☐ 100/year	
		OR				
		☐ 10 mL ENFit **OR** ☐ 20 mL ENFit			☐ 52/year	

Are you requesting non-standard or non-contract equipment? ☐ Yes ☐ No

If yes, please provide clinical justification for why standard equipment or contract items are not suitable:

Are you requesting a non-standard* allocation? ☐ Yes ☐ No

If yes, please provide clinical justification (as per clinical funding criteria) for why the standard allocation is insufficient, and attach relevant supporting documentation:

5. TRIAL OUTCOMES

Is the requested HEN equipment compatible with the person's existing products and equipment?

☐ Yes ☐ No

6. DELIVERY INFORMATION

Has the person's discharge date and destination been confirmed ☐ Yes ☐ No ☐ N/A

Please provide details

Is the person/carer aware of the local contact for ongoing clinical support ☐ Yes ☐ No

Please provide local contact name and contact details

Delivery Address

☐ Person's Home address

☐ Other: Name of contact	Phone
Address	Postcode

7. PRESCRIBER DECLARATION

☐ I declare that I have assessed the person and have the required qualification and level of experience to prescribe this equipment according to the Professional Criteria for Prescribers

OR

☐ I declare that I have assessed the person and I have been supervised by who is an eligible prescriber and has agreed to be nominated as my supervisor for this prescription

OR

☐ Dietician declaration: this equipment has been prescribed by a treating multi-disciplinary team and I have completed the equipment request on behalf of the team.

Team includes (names, professions of team including eligible prescribers):

AND

☐ I confirm that the person/carer is in agreement with this request

☐ I confirm a copy of this request will be provided to person/carer

☐ I understand that all information I have supplied on this application is true and correct to the best of my knowledge at the time of assessment

☐ I have read and understand my responsibilities and obligations as provided in the declaration above

Prescriber name	Qualification/Role
Name of service	AHPRA Registration Number
Address	Signature:
Email	
Phone	Date
Days/ hours available:	

Supervisor's details (if applicable)

Supervisor name	Qualification/Role
Name of service	AHPRA Registration Number
Address	Signature:
Email	
Phone	Date

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8. OTHER CONTACTS	
Name	Name
Address	Address
Phone	Phone
Email	Email
Qualification/Role	Qualification/Role

Please return to EnableNSW via email or mail

Email: enable@health.nsw.gov.au

Mail: EnableNSW, Health Support Services, Locked Bag 5270, PARRAMATTA NSW 2124