EnableNSW

Ventilator Circuits and Accessories 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 ☐ 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? *Please select one only*

☐ 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 specification

5. Does the person require ventilator circuits for a TGA approved device for continuous / life support ventilation OR nocturnal invasive (tracheostomy) ventilation: *Select ONE option below and provide any relevant details in the table below*

- ☐ No - Circuits are not required
- ☐ Yes - Disposable wet circuit only (52/year)
- ☐ Yes - Dry circuit only (Disposable 52/year)
- ☐ Yes - Dry circuit only (Reusable: 3/year)
- ☐ Yes - Combination of wet (26/year) and Dry circuits (Reusable: 3/year)
- ☐ Yes - Combination of wet (26/year) and Dry circuits (Disposable 26/year)

Ventilator Circuit requested (if selected in option above)	**Product Details**
☐ *Disposable wet circuit* *Product Code*	*Name* *Manufacturer*
☐ *Disposable dry circuit* *Product Code*	*Name* *Manufacturer*
☐ *Reusable dry circuit* *Product Code*	*Name* *Manufacturer*

6. Does the patient require external humidification equipment and consumables for invasive ventilation? *Select all that apply:*

Ventilator Circuit accessories requested - Equipment	**Product Details**	**Allocation**
☐ *Reusable resuscitator* *Product Code*	*Name* *Manufacturer*	*One only**
☐ *Test lung* *Product Code*	*Name* *Manufacturer*	*One only**

*Equipment marked as one only will be replaced at the end of an item's workable life or expiry date and a request is received from the person's prescriber.

7. Confirm which ventilator circuit accessories (consumables) are being requested. *Select all that apply*

Ventilator Circuit accessories requested - Consumables	**Product Details**	**Allocation**
☐ *Mouthpiece ventilation circuit* *Product Code*	*Name* *Manufacturer*	*20/year*
☐ *Humidifier chambers - reusable (ONLY if not included in wet circuit pack)* *Product Code*	*Name* *Manufacturer*	*3/year*
☐ *Heat Moisture Exchangers (HME) for dry circuit* *Product Code*	*Name* *Manufacturer*	*52/year*
☐ *Water bags for heated humidifier* *Product Code*	*Name* *Manufacturer*	*12/year*
☐ *Catheter mounts* *Product Code*	*Name* *Manufacturer*	*Per item:* *Disposable: 12/year* *OR* *Reusable: 3/year*
☐ *Expiratory valve/port for the circuit* *Product Code*	*Name* *Manufacturer*	
☐ *Connectors, elbows and swivels (i)* *Product Code*	*Name* *Manufacturer*	
☐ *Connectors, elbows and swivels (ii)* *Product Code*	*Name* *Manufacturer*	
☐ *Adaptors* *Product Code*	*Name* *Manufacturer*	
☐ *Other* *Product Code*	*Name* *Manufacturer*	

E. Eligibility and trial: ventilator circuits and accessories

8. Confirm ALL of the following to demonstrate eligibility for ventilator circuits and accessories:

- ☐ The person is using a TGA approved device for continuous / life support ventilation OR nocturnal invasive (tracheostomy) ventilation
- ☐ A one week trial of the prescribed equipment and consumables has been completed, and the person is tolerant of the prescribed equipment
- ☐ The person/carer has been trained and is competent in the use of the equipment
- ☐ The equipment/consumables being requested have been approved for community use

9. Ventilator - Select which device the requested ventilator circuit and consumables will be used with: *Select ONE option*

- ☐ Philips BiPAP A40
- ☐ Philips BiPAP A40 Pro
- ☐ Philips Trilogy Evo Philips
- ☐ Resmed Astral
- ☐ Trilogy 100
- ☐ ResMed Stellar 150

10. Humidifier base - Has a separate application for a stand-alone Humidifier been made to EnableNSW? *Select ONE Option*

- ☐ No - humidification not required
- ☐ No - alternative humidication option will be used
- ☐ Yes - Fisher and Paykel 950ANZ
- ☐ Yes - Fisher and Paykel MR810
- ☐ Yes - Fisher and Paykel MR850

11. Would you like EnableNSW to place the first order of respiratory consumables of this request on behalf of the person?

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

12. If Yes selected above, indicate the delivery location of respiratory consumables. *Select ONE option*

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

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

F. Prescriber eligibility and declaration

13. 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

14. 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

15. 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 Ventilation_circuits_accessories_equipment_John Smith_01.01.2022*