EnableNSW
Paediatric CPAP 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/hrp
- Full technical and physician reports of all relevant tests must be 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 health information of patients to allow EnableNSW to provide its services and use the information 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
- Share contact details with a supplier if additional support is required for set up of equipment if it is 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. Diagnostic and clinical information

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

4. Provide other relevant diagnosis/co-morbidities

D. CPAP equipment - intended use for weight and age

5. Provide child's weight (kg)

6. Select ONE relevant statement for Paediatric CPAP equipment intended use for weight and age

☐ Device being prescribed within the manufacturer's intended use for weight and age

OR

☐ Device being prescribed OUTSIDE of manufacturer's intended use for weight and age

If selected, *confirm ALL of the following:*

☐ I have attached a letter acknowledging that I have individually assessed the patient AND

☐ I have considered the suitability and safety of the prescribed CPAP or bilevel device for the patient AND

☐ This has been discussed with and consented by the child's family/guardian

E. CPAP device selection

7. Are you requesting a Standard/Non-Standard bilevel device to be set in CPAP mode?

☐ No - A standard fixed pressure CPAP device is being requested (select one of the following devices):

☐ Standard CPAP: ResMed Airsense 10 Elite

☐ Yes - child weighs <30 kg - *indicate device below and ensure the relevant script is attached*

☐ Yes - CPAP delivered via tracheostomy - *indicate device below and ensure the relevant script is attached*

☐ Yes - Patient requires CPAP at pressures >20cmH_2O - *indicate device below and ensure the relevant script is attached*

If yes selected above, provide device name:

F. CPAP adenoidectomy / tonsillectomy information

8. Select ONE of the following regarding adenoidectomy / tonsillectomy

☐ Adenoidectomy/ tonsillectomy surgery was not indicated or suitable for the child OR

☐ The child has had adenoidectomy/ tonsillectomy surgery, and a repeat diagnostic study was performed once the child stabilised post-surgery.

G. Paediatric CPAP diagnostic criteria

9. Provide diagnostic OAHI value AND select ONE diagnostic criteria AND attach the relevant sleep studies

Provide OAHI

☐ Diagnostic study demonstrating total OAHI ≥ 15/hr

☐ Diagnostic study demonstrating total OAHI ≥ 5-14/hr AND

If OAHI ≥ 5-14/hr, *select one option and attach the relevant sleep studies*

☐ Minimum oxygen desaturation ≤ 88%

☐ CO_2 retention ≥ 8 mmHg

☐ $TcCO_2$ > 50mmHg for 25% of the sleep study

☐ Letter attached documenting significant cardiorespiratory co-morbidities

H. CPAP treatment requirements

10. Confirm the following AND attach the relevant CPAP titration sleep study reports, AND other relevant tests/ correspondence, and/or current clinical justification letter

☐ CPAP pressure determination PSG demonstrating control of sleep-disordered breathing (SDB) (CPAP PD must be ≤ 2 years old)

I. Compliance report and clinical letter

11. Confirm ALL of the following AND attach relevant supporting documents *Note: CPAP trial report must be within last 4 months*

☐ Trial of fixed pressure CPAP at home for at least 2 consecutive weeks, demonstrating usage of ≥ 4 hours per night for ≥ 70% of nights

Provide percentage of nights used ≥ 4 hours (%) AND hours of usage per night (hours:min)

Percentage ☐ Hours:min ☐

☐ Recent clinical letter confirming that the person is clinically stable on long-term CPAP AND who will be responsible for ongoing review

J. CPAP device settings

12. Provide CPAP fixed pressure (cmH_2O) ☐

13. Ramp: on/off

☐ Off ☐ On - Provide ramp time ☐ and starting pressure (cmH_2O) ☐

14. Is pressure relief on exhalation required (e.g. EPR, C-Flex, softPAP)?

☐ No ☐ Yes - Provide pressure relief on exhalation settings:

☐

For ResMed devices indicate if EPR is: ☐ Ramp only OR ☐ Full-time

15. Provide any other CPAP device or humidifier settings

☐

☐

K. Primary interface and oxygen entrainment

16. What is the primary interface used with CPAP therapy?

☐ Full face mask ☐ Nasal mask ☐ Nasal pillows ☐ Oral mask ☐ Tracheostomy

17. Is supplemental oxygen entrained into the system?

☐ No ☐ Yes - Provide flow rate (L/min) ☐

Go to next page and complete Section L. Prescriber Eligibility and Declaration

L. 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

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 *CPAP request_John Smith_01.01.2022*