EnableNSW

Oxygen - Paediatric Short Term Oxygen Therapy (STOT) 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
- 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 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).

Paediatric STOT –use this form if oxygen is required post initial discharge from hospital following an acute admission

Registering the device with the person's electricity provider
As part of the person's emergency plan, please ensure they have contacted their electricity provider and registered details about their life support medical device. This should ensure the person receives adequate support during power outages. Additionally, the rebate form through Service NSW can be completed to assist with the cost of living www.service.nsw.gov.au/transaction/apply-for-the-life-support-energy-rebate-retail-customers

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. Diagnosis

3. What is the primary diagnosis in relation to the requested equipment? *Select ONE option*

- ☐ Bronchiolitis obliterans
- ☐ Cardiac failure intractable
- ☐ Chronic lung disease
- ☐ Congenital cardiac disease
- ☐ Cystic fibrosis
- ☐ Drug-related lung disease
- ☐ Oncology
- ☐ Pulmonary hypertension
- ☐ Other

4. Provide other relevant diagnosis/co-morbidities

D. Equipment specification

5. Select one stationary oxygen concentrator and specify flow rate: *Select ONE option*

- ☐ Oxygen concentrator standard flow (0-5 L/min). Flow rate (L/min)
- ☐ Oxygen concentrator high flow (6–10 L/min). Flow rate (L/min)
- ☐ Paediatric oxygen concentrator 0–1 L/min with 0.1 L/min increments (BOC areas)* Flow rate (L/min)
- ☐ Paediatric oxygen concentrator 0–2 L/min with 0.125 L/min increments (Supagas areas)* Flow rate (L/min)
- ☐ No oxygen concentrator requested

*Paediatric oxygen concentrator specifications vary. Please check with your supplier and provide a compatible flow rate

6. Select C size cylinders and specify flow rate: *Select ONE option*

- ☐ Portable oxygen C cylinders x2 with standard regulator x1. Flow rate (L/min)
- ☐ Portable oxygen C cylinders x2 with conserver regulator x1. Flow rate (L/min)
- ☐ No portable cylinders requested

7. Does the person use continuous oxygen (≥ 16 hours/day) AND reside > 2 hours from their closest hospital?

- ☐ No
- ☐ Yes – provide D Cylinder. Flow rate (L/min)

E. Current supplier of home oxygen

8. Does the person currently receive supply of home oxygen (e.g. hospital discharge supply)? *Select ONE option*

- ☐ No
- ☐ Yes-Initial oxygen supplied by BOC
- ☐ Yes-Initial oxygen supplied by Supagas

F. Short term oxygen therapy discharge information

9. Confirm ALL of the following have been addressed:

- ☐ The person is in hospital with an acute illness and in the recovery phase, nearing their date of discharge.
  Provide estimated or known discharge date from acute facility D D/M M/Y Y Y Y
- ☐ The first month's supply of oxygen has been funded by the discharging service

G. Stability, compliance and ongoing follow-up

10. Confirm ALL of the following have been addressed:

- ☐ The parents/guardians are aware that they will not be eligible for funding if they smoke
- ☐ Recommended oxygen equipment is compatible with the person's living environment
- ☐ The person/parents/guardians is/are aware that data regarding oxygen therapy usage will be collected by the supplier and can be obtained by the prescriber and EnableNSW
- ☐ Review for long term oxygen has been arranged. Provide follow-up date D D/M M/Y Y Y Y

H. Eligibility: oxygen concentrator

11. Select ONE of the oxygen usage requirements and complete the relevant criteria below:

☐ **Prescription is ≥ 16 hours/day** *Child fulfills the following criteria*

☐ Mean SpO_2 ≤ 93% OR until persistent desaturation SpO_2 ≤ 90% at rest for >1 minute OR SpO_2 < 80% for > 30 seconds (minimum 4 hours continuous oximetry recording time). *Attach technical and physician report.*

OR

☐ **Prescription is ≥ 6 hours/day (for nocturnal hypoxaemia)** *Child fulfills ONE of the following criteria*

☐ Mean SpO_2 ≤ 93% OR until persistent desaturation SpO_2 ≤ 90% at rest for >1 minute OR SpO_2 < 80% for > 30 seconds (minimum 4 hours continuous polysomnography or nocturnal oximetry recording on room air). *Attach technical and physician report of polysomnography or nocturnal oximetry.*

OR

☐ Technical and physician report of polysomnography demonstrating ≥ 3 nocturnal desaturations to ≤ 85% associated with central apnoeas and/or central hypopnoeas during artefact-free recording while breathing room air, that responds to oxygen *(copy attached)*

I. Improvement and stability on titrated oxygen flow rate

12. Confirm ALL of the following regarding stability and safety on prescribed oxygen:

☐ Provide technical and physician report of polysomnogram or nocturnal/continuous oximetry (minimum 4 hours) demonstrating objective improvement in SpO_2 on supplemental oxygen *(attached)* **AND**

☐ Objective evidence attached demonstrating oxygen therapy is not associated with significant CO_2 retention ≥ 10mmHg i.e. prolonged transcutaneous CO_2 recording, blood gas (arterialised capillary / arterial / venous) or bicarbonates

J. Eligibility: portable cylinder oxygen (C cylinders)

13. Confirm ONE of the following:

☐ Prescription is ≥ 16 hours/day

☐ The child requires oxygen therapy for nocturnal hypoxaemia only and requires daytime sleep due to age

☐ N/A - Portable cylinder oxygen is not requested

K. Funding portable oxygen cylinder refills

14. Confirm the following for portable oxygen cylinder requests:

☐ The person/parents/guardians are aware of and willing to partially fund the therapy including charges for portable C cylinder refills and delivery charges

☐ N/A - Portable Cylinder Oxygen is not requested

L. Community safety, education and emergency plan

15. Confirm ALL of the following three criteria will be addressed prior to the commencement of community oxygen therapy:

☐ A clinical assessment of the person indicates that they can be safely managed on the prescribed oxygen equipment in the community

☐ The person and family/carer/s will receive relevant education, and understand the risks and responsibilities to safely manage their oxygen therapy and the equipment in the community

☐ An individual care plan and an emergency plan will be communicated to the person and their family/primary carer/s, to manage both clinical and equipment emergencies, allowing the person to live safely in the community

M. Ongoing monitoring and assessment

16. Provide the details of the eligible clinician/prescriber who will continue to monitor the person: *Select ONE option*

☐ The prescriber for this request (Respiratory/Palliative Care Physician) will assess and monitor the person's condition

☐ A different eligible prescriber (Respiratory/Palliative Care Physician) will assess and monitor the person's condition

Provide name, qualification, phone number, email address and clinical service:

N. Prescriber eligibility and declaration

17. 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

18. 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

19. 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 Oxygen_Paeds_STOT_request_John Smith_01.01.2022*