EnableNSW
Tracheostomy Consumables 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? *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. Tracheostomy equipment selection

5. Tracheostomy tubes: *select ONE type of tracheostomy tube being requested*

- ☐ N/A - Tracheostomy tubes not being requested
- ☐ Disposable - Adult (12/year)
- ☐ Disposable - Paediatric or Single Lumen (52/year)
- ☐ Non-disposable (3/year)
- ☐ Custom made non-disposable (3/year) AND
  - ☐ I have attached the relevant custom made tracheostomy tube prescription template, which has been completed by the clinician who has the training to do so

6. Confirm which tracheostomy consumables are being requested: *Select all that apply*

Tracheostomy consumables requested	Product Details	Product Code	Allocation
Tracheostomy tubes: ☐ Non-disposable *OR*	*Name* *Supplier*		*3/year*
☐ Disposable – Adult *OR*	*Name* *Supplier*		*12/year*
☐ Disposable – Paediatric or Single lumen tracheostomy	*Name* *Supplier*		*52/year*
Disposable inner cannulas: ☐ Disposable inner cannulas – Adult tracheostomy *OR*	*Name* *Supplier*		*12/year*
☐ Disposable inner cannulas – Paediatric tracheostomy	*Name* *Supplier*		*52/year*
☐ Manometer for cuffed tracheostomy tubes	*Name* *Supplier*		*One only**
☐ One box of 10 mL syringes for cuffed tracheostomy	*Name* *Supplier*		*One only**
☐ Tracheostomy Heat Moisture Exchangers	*Name* *Supplier*		*365/year*
Tracheostomy securing device: ☐ Velcro Tapes (neck strap) *OR*	*Name* *Supplier*		*20/year*
☐ Cotton tapes	*Name* *Supplier*		*1 roll/year*
☐ Speaking valves	*Name* *Supplier*		*2/year*

*Equipment marked as one only will be replaced at the end of their expected life and a request is received from the person's prescriber.

E. Eligibility and trial: tracheostomy tubes and tracheostomy accessories

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

- ☐ The person requires the equipment for ≥12 months
- ☐ The tracheostomy tubes will not be changed in hospital (as an inpatient)
- ☐ The equipment / consumables being requested have been approved for home / community use
- ☐ The equipment / consumables being requested have been trialed (for at least 2 weeks) AND are effective and compatible with other equipment

8. Would you like EnableNSW to place the first order of tracheostomy tube consumables of this request on behalf of the person? *Select ONE option*

- ☐ No
- ☐ 3 months supply
- ☐ 6 months supply

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

F. Prescriber eligibility and declaration

9. 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

10. 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

11. 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/role AHPRA registration number

Phone number ( ) Email

Other contact 2

Name

Place of work

Address

State Postcode

Qualification/role 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 Tracheostomy consumables_John Smith_01.01.2022*