EnableNSW

Home Enteral Nutrition (HEN) 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
- EnableNSW is required to purchase products from NSW Government Contract 955. Non-contract products are only provided when a contract product does not meet the person's clinical need.

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 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 ☐ Amendment to existing request

Provide date of assessment D D/M M/Y Y Y Y

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, 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. Identification of need

5. Select indication for HEN: *Select ONE option*

- ☐ Complete nutrition and/or hydration
- ☐ Supplemental nutrition and/or hydration
- ☐ Other - describe in text box

E. Product category

6. What equipment are you requesting?

New Product	Replacement Product	Product Name	Code	Supplier	Allocation	Higher Allocation*
☐	☐	Gastrostomy tube			☐ 3/year	
		OR				
		Nasogastric tube			☐ 10/year	
		OR				
		Decompression tube			☐ 10/year	
☐	☐	Extension tubes			☐ 10/year	
☐	☐	Giving set-Category A (standard)			☐ 270/year	
		OR				
		Giving set-Category B or non-contract			☐ 270/year	
☐	☐	Containers			☐ 50/year	
☐	☐	Reusable Bolus/Water Flush Syringe				
		☐ 60 mL ENFit			☐ 52/year	
		OR				
		☐ 50/60 mL			☐ 100/year	
☐	☐	Reusable Water Flush Syringe/Dispenser				
		☐ 10 mL ENFit **OR** ☐ 20 mL ENFit			☐ 52/year	
		OR				
		☐ 10 mL **OR** ☐ 20 mL			☐ 100/year	

7. **Are you requesting Category B or non-contract equipment?** *Select ONE option*

☐ Yes ☐ No

If yes, outline reasons why Category A items are not suitable:

8. **Are you requesting a higher allocation?** *Select ONE option*

☐ Yes ☐ No

If yes, outline reasons (as per funding criteria) why the standard allocation is insufficient, and attach relevant supporting documentation:

F. Method of tube feeding

9. **Indicate the method of tube feeding:** *Select ONE option*

☐ Gastrostomy Tube

☐ Nasogastric (NG) Tube

Has NG tube feeding been established for 6 months or more?

☐ Yes-NG tube feeding has been established for 6 months or more

☐ No-NG tube feeding has not been established for 6 months

Provide clinical reasons for NG tube, including why gastrostomy tube is not suitable

☐ Other-provide details in text box

G. Regimen/Recommendations

10. **Select HEN regimen/recommendations:** *Select ALL that apply*

☐ Continuous via a pump

☐ Intermittent via a pump

☐ Bolus via a pump

☐ Gravity via a giving set

☐ Bolus via a syringe/dispenser

H. Eligibility and person/carer training

11. **Confirm ALL of the following and attach any relevant clinical letters/reports:**

Provide date when the person commenced tube feeding D D/M M/Y Y Y Y

☐ The requested HEN equipment has been trialled and is compatible with the person's existing products and equipment

☐ Person/carer has received training and written instructions on use and care of the equipment

☐ Person/carer is aware that there are supply allocations through EnableNSW and how they can purchase additional supplies if required

12. **Will the person require HEN for 12 months or longer?**

☐ Yes ☐ No

I. Ongoing monitoring and assessment

13. **Provide the details of the eligible clinician/prescriber who will continue to monitor the person's condition and provide ongoing support:** *Select ONE option*

☐ The prescriber for this request will assess and monitor the person's condition and provide ongoing support

☐ A different eligible clinician will assess and monitor the person's condition and provide ongoing support.

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

J. Prescriber eligibility and declaration

15. 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 ***Go to question 16***

☐ No – I do not have the level of experience to prescribe this type of equipment as required by the funding criteria.

The assessment of the person and the equipment request has been supervised by an eligible EnableNSW prescriber. Provide your supervisor's name and email address

Supervisor's name | Supervisor's email

16. 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

17. 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 *HEN_John Smith_01.01.2022*