

VICTORIAN AIDS AND EQUIPMENT PROGRAM: REQUEST FOR DOMICILIARY OXYGEN

Client Details (or affix UR Label)

UR Number _____

Name _____

Address _____

Date of Birth _____ Gender _____

Phone _____ Discharge Date _____

Hospital _____

PLEASE ENSURE ALL SECTIONS ARE COMPLETED OR ACKNOWLEDGED

DIAGNOSIS AND OXYGEN REQUIREMENTS

Adults

Evidence of

- COPD
- DILD
- Cor pulmonale
- Pulmonary hypertension
- Exercise-related hypoxia
- Sleep apnoea
- Terminal malignancy
- Advanced non-pulmonary or cardiac disease
- Other:

Applicant is

- On maximal therapy
- Clinically stable
- Non-smoker

Note that active smokers are ineligible

Applicant and/or carer is

- Able to understand and willing to abide by the safety requirements

Children

Continuous Oxygen

- Oxygen-dependent lung disease (including BPD)
- Cystic fibrosis with arterial oxygen desaturation
- Palliative care

Intermittent oxygen

- Severe life-threatening asthma (and living in remote area)
- Cystic fibrosis with desaturation during exercise
- Recurrent severe life-threatening upper airway obstruction

Nocturnal oxygen

- Central hypoventilation with hypoxaemia during sleep
- Cystic fibrosis with sleep-related hypoxaemia
- Recurrent apnoea of infancy that is otherwise therapeutically unresponsive

Other:

Applicant and/or carer is

- Able to understand and willing to abide by the safety requirements

SPIROMETRY AND DIFFUSING CAPACITY Ensure supporting documentation is attached DATE _____

	Predicted	Pre bronchodilator	Post bronchodilator
FEV ₁			
FVC			
FEV ₁ /FVC%			
DLCO			

BLOOD GASES (initial test) Ensure supporting documentation is attached DATE _____

	Flow rate	pH	PaCO ₂	PO ₂	SaO ₂	COHb	Hb
Air	-						
Intranasal O ₂							
Intranasal O ₂							

BLOOD GASES (retest) Ensure supporting documentation is attached DATE _____

	Flow rate	pH	PaCO ₂	PO ₂	SaO ₂	COHb	Hb
Air	-						
Intranasal O ₂							
Intranasal O ₂							

EXERCISE TEST (six minute walking test with oximetry) DATE _____

AIR	Rest	1 min	2 min	3 min	4 min	5 min	6 min
Pulse							
% Saturation							

INTRANASAL OXYGEN WITH CONSERVATION DEVICE SETTING _____ L/min

Pulse							
% Saturation							

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DOB _____ UR Number _____

OXYGEN REQUIREMENTS

Oxygen via Face mask Nasal cannula
Duration of therapy Nocturnal Intermittent Continuous _____ hrs/day
Flow rate L/min
Regulators / Flow meters (children) Low flow High flow

EQUIPMENT

Concentrator

Portable cylinders Size _____ Number _____

Back-up cylinders Size _____ Number _____
Justification _____

Accessories Conservation device
 Stroller kit
 Carry bag
 Other _____

FURTHER COMMENTS

ADDITIONAL QUESTIONS

Was oxygen required on discharge from hospital? Yes No
Was oxygen supplied free of charge for 30 days following discharge? Yes No
Is client currently receiving oxygen therapy? Yes No
If so, please state supply company _____

LABORATORY / TESTING FACILITY CONTACT (if applicable)

Name _____ Job Title _____
Pager No _____ Phone No _____ Department _____

PRESCRIBING PHYSICIAN

Name (please print) _____ Phone no _____
Address _____
Signature _____ Date _____

Provision of funding for oxygen gas and associated equipment for domiciliary oxygen therapy will be in accordance with the Position Statement (guidelines) established by the Thoracic Society of Australia and New Zealand (TSANZ).

For further details on adults see Medical Journal of Australia 2005;182:621:626 at:http://www.mja.com.au/public/issues/182_12_200605/mcd10865_fm.html

For further details on children see TSANZ Position Statement for Infants with chronic neonatal lung disease: recommendations for home oxygen therapy in children at: <http://www.thoracic.org.au/oxygentherapydoc01.pdf>

DEPARTMENT OF HUMAN SERVICES RESPIRATORY CONSULTANT

Comments: _____

Approved Not Approved

Signature _____ Date _____

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PROGRAM REQUEST FOR
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APPLICANT DECLARATION

Name _____
DOB _____ UR Number _____

I confirm that my signature below represents:

- My agreement to enquiries being made by the Department of Human Services or its agent, to other individuals and organisations, for the purpose of obtaining information about eligibility and assessment for the requested aids and equipment.
- My understanding that all the information I have supplied on this application is true and correct to the best of my knowledge.
- My understanding that this application is not a formal approval or guarantee of A&EP services.
- My understanding that the Victorian A&EP is not available to people who have received compensation or damages in respect of their Disability. But if the prospective recipient has made, or is intending to make such a claim, the Victorian A&EP service provider shall serve on the recipient notice of liability on the part of the recipient to pay the Victorian A&EP service provider a sum equal to the cost of the equipment, and the Victorian A&EP service provider will seek to arrange for those liabilities to be included in recipient's claim for damages.

Authorised
Representative or
Client **Signature** _____

Date _____

ADDITIONAL CONSENT

In order to improve the services it delivers Disability Services may need to use information about you. Your assistance in providing consent for this is appreciated.

I consent to information about me possibly being used for service monitoring, evaluation, planning and to improve the quality of services provided to me.

Authorised
Representative or
Client **Signature** _____

Date _____

PRIVACY STATEMENT

Disability Services is committed to protecting the confidentiality of your personal information. There are provisions in the Disability legislation that protect the confidentiality of your information. The Health Records Act 2001 provides additional safeguards and protections for your information. Information that you have provided will only be used to provide services that you request and will not be used for any other purposes without your express consent. You have the right to request access to your information and to have it corrected where it is inaccurate, out of date, incomplete or misleading. For more information about your privacy rights you can visit the DHS website at www.dhs.vic.gov.au/privacy or the Office of the Health Services Commissioner at www.health.vic.gov.au/hsc

Victorian Aids and Equipment Program (A&EP)

Oxygen Usage Monitoring Form

Client's name
Referring physician
Actual pattern of oxygen usage as reported by oxygen supply company
Prescribed pattern of oxygen usage

Please contact your client and examine the reason for the above discrepancy and give all necessary usage instruction to the client.

Please fill in the space below indicating action taken
Is oxygen therapy to be continued? Yes No
Please confirm above prescription

Please return to Victorian A&EP issuing centre within two weeks.

Aids and Equipment issuing centre:

Address:

Phone Number: