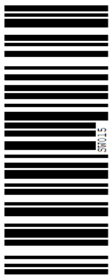

Annual Review Form | Domiciliary Oxygen

Adult & Child

swep State-wide equipment program

PLEASE ENSURE ALL SECTIONS ARE ACKNOWLEDGED TO ENSURE SUPPLY CONTINUES

Attention: Domiciliary Oxygen Program, SWEP, PO Box 1993 Bakery Hill Victoria 3354 or swepoxy@bhs.org.au

Review Date:

1 – Client Details

Title ☐ Mr ☐ Mst ☐ Mrs ☐ Ms ☐ Miss ☐ Other -

Surname Given Name/s

DOB

Address: Unit No. No. Street Name

Suburb Postcode Is this a CRU? ◯ Yes ◯ No

Contact: Home Mobile

2 - Client Diagnosis (please tick all relevant boxes) Adults

Adults

☐ COPD ☐ Interstitial Lung Disease ☐ Pulmonary Arterial Hypertension

☐ Bronchiectasis ☐ Sleep-Disordered Breathing ☐ Other

☐ Terminal Malignancy (please specify)

☐ Advanced cardiac disease (please specify)

Children

☐ Bronchopulmonary Dysplasia ☐ Bronchiectasis ☐ Sleep-Disordered Breathing

☐ Cyanotic Congenital Heart Disease ☐ Severe life-threatening asthma (and living in remote area) ☐ Palliative Care

3 – Additional Questions

Does your client continue to be a non-smoker? ☐Yes ☐No
(If no please indicate below that you have discussed with your client that funding will now cease)

Is your client aware that funding will cease if they are found to be smoking in future? ☐Yes ☐No

Does your client currently receive an Australian Government Home Care Package? ☐Yes ☐No
(If yes please state the Case Manager's Name and contact details below)

Is your client currently residing in an Aged Care Facility? ☐Yes ☐No
(If yes please state the Name and contact details of the facility)

Further details

4 – Equipment Details

The current holdings and flow rate of the client are:

Concentrator Flow Rate (Rest) [ ] lpm Flow Rate (Nocturnal) [ ] lpm Hours per day [ ]

Portable cylinder/s Flow rate (intermittent/on exertion) [ ] lpm No. of Cylinders [ ]

If you wish to alter the prescription and/or holdings please state the new prescription below: (you may be required to submit further test results as per the TSANZ Guidelines for consideration by the DHS Respiratory Physician):

Concentrator Flow Rate (Rest) [ ] lpm Flow Rate (Nocturnal) [ ] lpm Hours per day [ ]

Portable cylinder/s Flow rate (intermittent/on exertion) [ ] lpm No. of Cylinders [ ]

Portable Concentrator Setting [ ] NB. The client must be tested on the requested POC to determine the appropriate machine setting.

5 - Additional Medical Information

6 – Review Assessment/s Undertaken

If this Review is to amend the applicants oxygen supply to include a different method of supply (eg add concentrator) then assessments as per the TSANZ Guidelines must be completed with appropriate evidence recorded and attached to this application for consideration by the DHS Respiratory Physician *(note: if all appropriate evidence is not included with this review it will be returned)*

Arterial Blood Gases **Date**

	Flow Rate	pH	PaCO2	PO2	SaO2	COHb	Hb
Air							
Intranasal O2							
Intranasal O2							

Exercise Testing (six minute walking test with oximetry)

Date **Distance Walked**

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

Intranasal Oxygen with Conservation Device Set at [ ] litres per minute

Date **Distance Walked**

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

Home Oximetry Testing (please enter test results below) **Date**

Spirometry and Diffusing Capacity **Date**

	Predicted	Pre Bronchodilator	Post Bronchodilator
FEV1			
FVC			
FEV1/FVC%			
DLCO			

Further comments:

7 – Testing Facility Contact (if applicable)

Contact Person Position

Facility Name Phone

8 - Prescribing Physician Details

SWEP Registration Number Name Signature

Organisation

Best Contact: Phone Fax Email

****If you are a SWEP registered GP and you wish to make a change to the Prescription, the treating Physician must validate the change Section 9*****

9 – Validating Physician Details (if required)

Refer to SWEP Domiciliary Oxygen Prescriber Registration and Credentialing Framework

SWEP Registration Number Name Signature

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*