Prescription Form | Domiciliary Oxygen

Adult & Child

NB: All relevant fields must be completed otherwise the form will be returned for completion.
Please ensure that copies of relevant supporting test results are attached.

PLEASE ENSURE ALL SECTIONS ARE COMPLETED OR ACKNOWLEDGED AND SEND TO
Attention: Domiciliary Oxygen Program, SWEP, PO Box 1993 Bakery Hill Victoria 3354 or swep_oxy@bhs.org.au

Prescription Date:

1 - Client Details

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

Surname Given Name/s

Address:

Contact: Home Mobile Email

Is the applicant an existing SWEP client? ○ Yes ○ No

(if no please complete the SWEP Eligibility form and submit it with this prescription)

2 - Client Diagnosis (please tick all relevant boxes)

Adults

☐ COPD ☐ Interstitial Lung Disease ☐ Pulmonary Arterial Hypertension (attach ECHO)

☐ 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

☐ Other

3 – Client Expectations

☐ The clients expectations have been considered in the prescription of this equipment

4 – Additional Questions

☐ Client is a non-smoker/has ceased smoking.

☐ Client is aware that they will not be eiligible for funding if they continue to smoke

Date client is/was discharged from a ☐ Public Hospital ☐ Private Hospital

NB: Private hospital clients will only be 'provisionally approved' pending 30 day review

Was oxygen required on discharge from hospital? ○ Yes ○ No

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5 – Assessment/s Undertaken

Assessments as per the TSANZ Guidelines must be completed with appropriate evidence recorded and attached to this application *(note: if all appropriate evidence is not included with this application it will be returned)*

Arterial Blood Gases (current) **Date**

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

Exercise Testing (six minute walking test with oximetry) **Date**

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

Distance Walked Borg score end of test

Intranasal Oxygen Set at litres per minute Set at litres per minute

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

Distance Walked Borg score end of test

Spirometry and Diffusing Capacity **Date**

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

Echocardiogram **Date** RVSP mmHg PASP mmHg

Sleep Study **Date** Percentage of sleep time SpO2 ≤ 88%

Other Results (if applicable)

6 – Testing Facility Contact (if applicable)

Contact Person Position

Facility Name Phone

7 – Prescription Details

Concentrator **Flow Rate** ☐ **lpm** **Hours per day** ☐ ☐ Nocturnal Only

Please complete ABGs in section 5

If client PaO2 is 56-59mmHg does your client fulfil the following criteria? (Attach ECHO and/or state clinical signs in section 8)

☐ Pulmonary Hypertension ☐ Right Heart Failure ☐ Polycythemia ☐ Other

☐

Portable cylinder/s **Flow rate** ☐ **lpm** **No. of Cylinders** ☐

Please complete walk test results in section 5.

NB. All Cylinder packages include CH cylinders, trolley & OCD unless specified below

If this equipment is to be used with any other respiratory equipment or support, please specify below.

8 – Further Information

☐

9 – Additional Equipment

Portable Concentrator (POC) **Machine Setting** ☐

Please complete walk test results in section 5.

NB. The client must be tested on the requested POC to determine the appropriate machine setting

Only applicable for a client who exceeds 8 cylinders per month and does not require a stationary concentrator

10 – Delivery Instructions

Please outline any security risks or special instructions which may impact on equipment delivery

☐

11 – Prescriber Details

SWEP Registration Number ☐ Name ☐ Signature ☐

Organisation ☐

Best contact Phone ☐ Fax ☐ Email ☐

12 – Validating Physician Details (if required)

Refer to SWEP Domiciliary Oxygen Prescriber Registration and Credentialing Framework

SWEP Registration Number ☐ Name ☐ Signature ☐

OR

Refer to SWEP Clinical Advisor ☐

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.pd*