 **Annual Review Form** Domiciliary Oxygen

 Annual Review Form Domiciliary Oxygen - Adult & Child

 Adult & Child

**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      

Surname  Given Name/s 

 DOB 

Address: Unit No.    No.  Street Name 

Suburb  Postcode Is this a CRU? 

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 

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[ ]  Terminal Malignancy (please specify)



[ ]  Advanced cardiac disease (please specify)

**Children**

**[ ]**  Bronchopulmonary Dysplasia[ ]  Bronchiectasis [ ]  Sleep-Disordered Breathing

[ ]  Cyanotic Congenital Heart Disease [ ]  Severe life-threatening asthma [ ]  Palliative Care

 (and living in remote area)

**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 

SW015

**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**

SW014

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*](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*](http://www.thoracic.org.au/oxygentherapydoc01.pdf)