



Annual Review Form

Adult & Child

Domiciliary Oxygen



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

Review Date:

1 – Confirm 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 – Confirm Client Diagnosis

Adults

☐ Advanced non-pulmonary or cardiac disease ☐ Asbestosis ☐ Bronchiectasis

☐ COPD ☐ Cor Pulmonale ☐ DILD

☐ Exercise Related Hypoxia ☐ Lung Cancer ☐ Morbid Obesity

☐ Sleep Apnoea ☐ Pulmonary Hypertension (attach ECHO Report)

☐ Terminal Malignancy (please state) ☐ Other

Applicant is

☐ On maximal therapy ☐ Clinically stable ☐ Non Smoker (active smokers are ineligible)

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

☐ Cystic fibrosis with sleep-related hypoxaemia

☐ Central hypoventilation with hypoxaemia during sleep

☐ Recurrent apnoea of infancy that is otherwise therapeutically unresponsive

☐ Other

3 – Equipment Details

Please complete the below information to confirm the current holdings and flow rate of the client:

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

4 - Additional Medical Information:

5 – 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

	Flow Rate	pH	PaCO ₂	PO ₂	SaO ₂	COHb	Hb
Air	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Intranasal O ₂	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Intranasal O ₂	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Exercise Testing (six minute walking test with oximetry)

Date Distance Walked

	Rest	1min	2min	3min	4min	5min	6min
Pulse	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
% Saturation	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Intranasal Oxygen with Conservation Device

Set at litres per minute

	Rest	1min	2min	3min	4min	5min	6min
Pulse	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
% Saturation	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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:

--

6 – Testing Facility Contact (if applicable)

Contact Person		Position	
Facility Name		Phone	

7 – Additional Questions

- Is the client or carer able to understand and willing to abide by the safety requirements? ☐ Yes ☐ No
- Is the client or carer aware that if the personal details of the applicant change they are to notify SWEP? ☐ Yes ☐ No
- Is the client aware that if it is evident they are smoking funding will cease for the equipment supplied by SWEP immediately? ☐ Yes ☐ No
- Is the client aware that it is a requirement of their continued support from SWEP they are to attend a 12 month review by their specialist? ☐ Yes ☐ No

8 - Prescribing Physician Details

Prescriber Name		Prescriber Signature	
Medicare Provider Number			
Qualification Details			
<input type="checkbox"/> Respiratory Physician	<input type="checkbox"/> Specialist Physician (please specify)		<input type="checkbox"/> Cardiologist
<input type="checkbox"/> Medical Oncologist	<input type="checkbox"/> General Practitioner Rural areas only (contact SWEP to confirm application details)		
Prescriber Organisation:			
Prescriber Address			
Contact for Prescription Queries	Phone		Email

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>

