

Application for Home Medical Oxygen Therapy

The prescriber is responsible for ensuring that the client is aware that their personal information is to be forwarded to DVA, and companies authorised by DVA to deliver products, for determining and/or providing benefits under the *Veterans' Entitlements Act 1986*. The information will be treated in a confidential manner. However, in certain circumstances it may be used for clinical review, audit or management purposes or disclosed to the client's local medical officer.

For any queries regarding the completion of this form please contact the DVA's Rehabilitation Appliances Program Section on (07) 3223 8623.

Patient/Entitled	Person - De	livery Details	S								
Surname											
Given names											
Address								Pos	tcode		
Phone number	()			Date of birth	/	/		Gender	Male	Fema	ıle
DVA file number											
Card type	Gold	White	eligibility u	Card holders it inder the patie i 300 131 945	nt's Accepte	ended that ed Disabilit	the preso y(ies). Pl	criber cor ease call	ntacts DVA 133 254 (n	to check earest State	
Delivery address (if different to above)								Pos	tcode		
Prior Approval number (when required and issued by DVA)			Comm Reside	he patient live nonwealth func ential Aged Car y (RACF)?	led 📖 🗀	No Ye	es → If Y be Ag DV	ed Care A	ing oxygen I by the RAC Act 1997 an	treatment w CF under the d not throu	ʻill e gh
Specialist Physic	cian Details										
In accordance with practitioner is not avare provided.	DVA Guideline vailable for per	es for Prescriber sonal endorsem	rs, where a re lent, a verba	espiratory phy I endorsement	sician, card is acceptab	iologist, or ble provide	ncologist d that th	or other e name, a	DVA approaddress and	oved medical other deta	al ils
Prescriber's Stamp (if applicable)		Speciality									
		Name									
		Address									
		Provider						Post	tcode		
		number									
		number	()								
		Fax number]		
		Signature				/	/				
Local Medical C	Officer Detai	ils									
This section should l	be completed v	when possible.									_
Prescriber's Stamp (if applicable)	Name									_
		Address									_
		Provider				Postcode					
		number Phone									
		number									
		Fax number	()]		
		Signature				/	/				

Medical Conditions	_	If a patient's condi	tion falls outside of DVA Guidel case briefly outline any exception	ines for home
Chronic Obstructive Pulmonary Disease	Interstitial Fibrosis	Oxygen dierapy, p.e.	ase offerly outline any exception	ai circumstances.
Pulmonary Hypertension	Polycythaemia			
Ischaemic Heart Disease	Asthma			
Cardiac Failure	Lung Malignancy			
Other - specify		Requested Supp	oly System	
		Concentrator	, ,	
		Back up cyline	der (for blackout prone areas)	
Indications for Oxygen Therapy		E or D size (69	90L or nearest equivalent)	
Chronic Hypoxia		NOTE: The followin	g portable cylinders will normally	only be provided
Arterial Blood Gases at rest on room treatment during a stable phase of the	air (while on optimised e illness).	if oxygen is require the ability to mobil where these sizes a equivalent.	d for less thán 4 hours per day ór ise. Cylinder sizes are provided ire not available should reflect th	if the patient has as a guide and eir nearest
Date / /		Portable oxyge	en — 160L 2	50L 480L
PaO ₂ mm Hg pH	PaCO ₂ mm Hg	Oxygen conse		meter/Regulator
Isolated Nocturnal Hypoxaemia Nocturnal oxygen saturation		Carry bag	OR Troll	O .
(for isolated nocturnal hypoxaemia o	nly) %	Oxygen Prescri	ption	
Exertional Hypoxaemia		Flow R	•	
Patients are exercised (step or timed wa	alk) until they reach oxygen	At rest	I/min	
desaturation of 90%. Exercise is then a goal of exceeding number of steps keeping saturation above 90%. Meas	or distance walked and	Exercise	l/min	
distance or steps walked and duration	n of exercise.	Sleep	l/min	
Date / /		Hours per day		
Room Air C	Only Using Supp O2	Oxygen is required		
O ₂ flow (L/min)		Flow rate during Asthma attack	I/min → Mask	OR Prongs
Rest (SaO ₂)		Please state any fu	uthou instructions	
End exercise (SaO ₂)		Please state any fu	rther instructions	
Distance (m) / Steps completed				
Exercise duration (Mins)				
Acute Asthma				
Does the patient suffer from sudden I	ife threatening asthma			
despite appropriate maintenance the	rapy?	- I I I	5 1	
Yes No		Fax the completed South Australia	Daw Park Repatriation Hospital	(08) 8277 9401
Cardiac Disease			Wymedical BOC Limited	(08) 8338 6022 1800 624 149
Does the patient suffer from end stage no further interventions are feasible?	e cardiac disease for which		ALH	(08) 8331 1849
Yes No		Broken Hill	Wymedical ALH	(08) 8338 6022 (08) 8331 1849
		Western Australia	BOC Limited	1800 624 149
Palliative		Tasmania	BOC Limited	1800 624 149
Does the patient suffer from lung can life expectancy of less than six month	cer and have an estimated	Northern Territory Queensland	BOC Limited ALH	1800 624 149 (07) 3252 4850
expectancy of less than six months?	or ourerwise have a me	NSW / ACT	ALH	(02) 8338 9797
Yes No		Victoria	ALH	(03) 9496 3723
Thank you for completing this form				
If this form was completed by a business with function of the time actually spent reading the i	. , .	•	·	
• the time spent by all employees in c			Hours	Mins