# WESTERN AUSTRALIAN DOMICILIARY OXYGEN REFERRAL FORM

| **REFERRAL to:** ☐ **Silver Chain** ☐ **WACHS** ☐ **Residential Care** | **DATE:** |
|---|---|

Addressograph / Label ➔ (if available) ➔

## SECTION 1: PATIENT DETAILS

| | | |
|---|---|---|
| Patient Name: | | |
| Patient Contact Number: | Gender: | DOB: / / |
| Residential Address: | | ☐ Inpatient ☐ Outpatient |
| Delivery Contact Name: | Delivery Contact Number: | |
| Smoking Status: ☐ Current ☐ Never | ☐ Ex-Smoker [Date last smoked: ] | |
| General Practitioner: | Patient is aware of the referral: ☐ Yes ☐ No | |

## SECTION 2: REFERRER DETAILS

☐ Respiratory Physician ☐ Palliative Care Physician ☐ Hospice General Practitioner
☐ Cardiologist ☐ Oncologist ☐ Sleep Physician ☐ General Practitioner in Non-Metro Area

| | | |
|---|---|---|
| Name: | Practice Location: | Contact Number: |
| Address: | | Fax Number: |
| Email: | Provider Number: | **Signature:** |

***Prescription:** ☐ Initiation ☐ Interim Review ☐ Annual Review ☐ Cancellation

***Domiciliary oxygen equipment will be removed by the service provider unless a confirmation of review and need for ongoing oxygen prescription is received within the recommended timeframe, or after 2 requests, or notifications, from service provider.**

Please select indication from Sections 3, 4 or 5 and provide the required evidence.

## SECTION 3: RESPIRATORY INDICATIONS FOR OXYGEN THERAPY

*Primary diagnosis for consideration of oxygen therapy:*

☐ Chronic Obstructive Pulmonary Disease/ Chronic Airways Disease ☐ Pulmonary Hypertension
☐ Pulmonary Fibrosis ☐ Sleep Disordered Breathing ☐ Other Chronic Respiratory Disease

**Prescribed Flow Rate (L/min): Rest Sleep Ambulation**

*Please select one of the following prescription options and provide relevant mandatory results:*

☐ **Long term continuous oxygen therapy for usage greater than 18 hours per day**

ABG (room air, at rest when stable): $pO_2$:_____ $pCO_2$:_____ $SpO_2$:_____
6MWT Room Air:_____ $SpO_2$:_____ Distance:_____
6MWT _____L/min $O_2$ $SpO_2$:_____ Distance:_____
Date and location of interim review at 3 months:_____

☐ **Nocturnal oxygen**

Report attached for: ☐ Overnight recorded pulse oximetry ☐ Sleep Study

☐ **Ambulatory oxygen for profound exertional desaturation without resting hypoxia**

6MWT Room Air:_____ $SpO_2$:_____ Distance:_____ Borg:_____
6MWT _____L/min $O_2$ $SpO_2$:_____ Distance:_____ Borg:_____
Date and location of interim review at 3 months:_____

☐ **Short term oxygen**

ABG (room air, at rest): $pO_2$:_____ $pCO_2$:_____ $SpO_2$:_____
6MWT Room Air:_____ $SpO_2$:_____ Distance:_____ Borg:_____
6MWT _____L/min $O_2$ $SpO_2$:_____ Distance:_____ Borg:_____
☐ Respiratory physician supporting letter attached for initiation script
Date and location of interim review at 6 weeks:

## SECTION 4: PALLIATIVE OXYGEN THERAPY

**Prescription Flow Rate (L/min): Rest** _____ **Sleep** _____ **Ambulation**_____
$SpO_2$ (Room Air):_____ **OR** $pO_2$ on ABG:_____
Physician estimated survival less than 3 months ☐ Yes ☐ No
Physician reassessment if usage beyond 6 months from initial prescription:
$SpO_2$ (Room Air): $pO_2$ on ABG:

## SECTION 5: MAXIMALLY TREATED CHRONIC HEART FAILURE WITH SYMPTOMATIC SLEEP APNOEA IN PATIENTS INTOLERANT OF A CPAP DEVICE

**Prescription Flow Rate (L/min): Rest** _____ **Sleep** _____ **Ambulation**_____
☐ Sleep study report attached

**Fax referrals to:**
**Silver Chain** Fax: 1300 601 788 Phone: 08 9242 0242
**WACHS** Contact local health service http://wachs.hdwa.health.wa.gov.au/

Version 3
September 2019

## CONTRAINDICATIONS for DOMICILIARY OXYGEN THERAPY

- Current smokers or e-cigarette users
- Smoking not ceased within 6 weeks of prescription for short term oxygen therapy in patients who smoked until the index admission
- Patients without evidence of hypoxaemia at rest and/or exertion as defined by the indication criteria
- Patients who have not received adequate investigation or therapy relevant to their condition.
- Patients who are not motivated to or do not have capacity to use oxygen for the recommended duration or at the prescribed oxygen concentration after the trial period.

## INDICATIONS FOR DOMICILIARY OXYGEN THERAPY

### 1. RESPIRATORY INDICATIONS

Patients with chronic respiratory conditions may be eligible for the following types of oxygen therapy. In most instances, referrals will only be accepted from respiratory and sleep physicians. In regional areas where access to respiratory physician is limited, referrals in accordance with the current guideline can be accepted from GP or general physicians. Responsibility for review lies with the initiating doctor unless otherwise specified via formal correspondence. If patient requires review by an alternative physician or location, please ensure appropriate referral process is communicated and in place.

#### *1.1 Long term continuous oxygen therapy*

This is indicated in chronic respiratory conditions such as, but not limited to chronic obstructive pulmonary disease , when there is evidence of hypoxaemia defined as:

- Stable daytime $PaO_2 \leq 55$mmHg
- Stable daytime $PaO_2$ 56 - 59 mmHg and evidence of organ damage (right heart failure, cor pulmonale, or polycythaemia) and/or pulmonary hypertension

ABG and 6MWT must be performed when **stable**, at least 4 weeks after hospital discharge, after initiation of appropriate medical therapy and after smoking cessation. ABG must be taken on room air at rest (i.e. at least 10 minutes after exertion). 6MWT is required if prescription for ambulatory oxygen flow rate is above that used for rest or sleep or if ≥ 6L/min is required. Appropriate ambulatory flow rate should be adjusted to maintain $SpO_2 \geq 90\%$. 6MWT is required for annual renewal of oxygen script.

#### *1.2 Nocturnal oxygen*

This is for individuals with lung disease who desaturate to less than $SpO_2$ 88% for more than one third of the night, especially in the presence of pulmonary hypertension or polycythaemia (haematocrit >0.55).

In those not suspected of sleep apnoea or nocturnal hypoventilation, overnight recorded pulse oximetry is suitable (intermittent observation and documentation of oxygen saturations in a hospital setting is not appropriate). In those suspected of sleep apnoea or sleep hypoventilation (e.g. a serum bicarbonate > 28mMol/L) a level 2 or 1 sleep study is preferred.

#### *1.3 Ambulatory oxygen for profound exertional desaturation without resting hypoxia*
***This should not be routinely provided on discharge from hospital***

This option should be carefully considered for patients without resting hypoxia but who may benefit in exercise endurance, degree of dyspnoea AND exertional oxygen desaturation.

For initiation of therapy, 6MWT on room air when stable should demonstrate a nadir $SpO_2 < 84\%$ for those with chronic lung disease.

For ongoing therapy beyond 3 months, there must be documented benefits in exercise ability, daily functional capacities (e.g. Improvement in 6MWT >30m) and/or improvement in dyspnoea score >1, improvement in endurance walk test or supportive clinician/allied health functional assessment outcome.

#### *1.4 Short term oxygen therapy*
***This should not be routinely provided on discharge from hospital***

This is only for patients with confirmed background chronic lung disease with profound hypoxia defined by $SpO_2$ <84% at rest or with exertion after a period of appropriate therapy for causes of acute deterioration. Patients must agree to abstain and engage in smoking cessation post discharge if they smoked until the time of hospital admission.

ABG (at rest and on room air) and 6MWT (on room air and on appropriate level of oxygen titrated to maintain $SpO_2$ ≥90%) is required. The referral must also be accompanied by a supporting letter from a respiratory physician outlining need and expected goal of oxygen therapy.

Repeat ABG and/or 6MWT is mandatory at 6 weeks review to determine if patient qualifies for other indications of oxygen therapy.

### 2. PALLIATIVE OXYGEN THERAPY

***This indication should <u>not</u> be used for patients with chronic lung diseases who should otherwise be considered for other indications for oxygen therapy.***

Palliative oxygen therapy is for patients with terminal illness including malignancy where hypoxaemia ($SpO_2$ ≤88% or $PaO_2$ <55mmHg) coexists with intractable dyspnoea despite maximal therapy.

Ongoing use of oxygen for this indication beyond 6 months from the initial script will require re-assessment by a physician to determine if other indications are more appropriate.

### 3. MAXIMALLY TREATED CHRONIC HEART FAILURE WITH SYMPTOMATIC CENTRAL SLEEP APNOEA IN PATIENTS INTOLERANT OF A CPAP DEVICE

Patient must be under active care of a cardiologist for maximally treated heart failure with co-existing central sleep apnoea but intolerant of CPAP therapy. The referral must be accompanied by a sleep study report issued within 12 months of referral.

### 4. PRESCRIPTIONS OUTSIDE THE ABOVE INDICATIONS

Prescriptions for oxygen therapy falling outside the above indications may be submitted for review by an external expert panel as determined by the service provider for domiciliary oxygen therapy. A supporting letter from referring clinician is required to outline the reason(s) for oxygen therapy and the expected benefit or goal of treatment.

## FURTHER INFORMATION

For further information and a full description of indications and contraindications visit the Thoracic Society of Australia and New Zealand website: www.thoracic.org.au.

Alternatively, for clinical support contact the Respiratory Physician at your nearest hospital.

**Residential Aged Care Facilities** – For patients requiring oxygen in residential aged care facilities, the cost is borne by the Commonwealth Department of Health and Ageing. Written certification from a medical practitioner stating that the care recipient has a continual need for the administration of oxygen is required to be attached to the form. A sample proforma letter is provided with the Prescription Form.

More information can be found at: https://www.humanservices.gov.au/organisations/health-professionals/forms/ac011

**Energy Subsidy** – The Life Support Equipment Energy Subsidy Scheme is available to help financially disadvantaged persons, or their dependents, to meet the energy costs associated with operating life support equipment in their home, under specialist medical advice. The State Government Department of Finance requires medical authorisation to be completed in full for the patient to receive the subsidy.

It is also essential to inform patients to contact their electricity retailer to register as a Life Support customer as soon as possible. Details can be found on electricity retailers' websites or by phoning them directly.

More information can be found at:
https://www.finance.wa.gov.au/cms/uploadedFiles/_State_Revenue/Other_Schemes/Life_Support_Equipment_Information_Sheet.pdf?n=8629

## POLICY REVISIONS AND REVIEW PLAN

The Western Australian Domiciliary Oxygen Therapy Referral Form ("Referral Form") replaces the Operational Directive 0616/15 Provision of Domiciliary Oxygen All Public Health Services in Western Australia.

The revision of the Referral Form was undertaken by the Domiciliary Oxygen Therapy Working Group under the stewardship of the Respiratory Health Network, in consultation with all public hospital Respiratory Departments and other relevant Respiratory Specialities and Stakeholders.

The Referral Form and the Western Australian Domiciliary Oxygen Therapy Information Sheet ("Information Sheet") were revised in line with update best practice guidelines.

Recommendations made in the Information Sheet are based on the Adult Domiciliary Oxygen Therapy Position Statement of the Thoracic Society of Australia and New Zealand and other related evidence-based guidance.

While the current policy is not mandated, the Referral Form and Information Sheet outline the recommended best practice for WA. The Referral Form will be the only form accepted state-wide from November 2019, after a transition period of 3 months.

The Referral Form and Information Sheet will be revised in 3 years.

**Version Control**

| Title and Classification | Version | Notes and Date |
|---|---|---|
| Western Australian Domiciliary Oxygen Referral Form<br>Western Australian Domiciliary Oxygen Therapy Information Sheet | 3 | Revised and Amended<br>September 2019 |
| Operational Directive<br>OD 0616/15 Provision of Domiciliary Oxygen All Public Health Services in Western Australia | 2 | Amended<br>January 2012 |
| Operational Directive OD 0221/09<br>Operational Instruction OP 1644/03<br>Technical Bulletin 75/0<br>CRC-PP14 (3p) | 1 | Created<br>September 2009 |

**Reference**

McDonald CF, Whyte K, Jenkin S, Serginson J and Frith P. Clinical Practice Guideline on Adult Domiciliary Oxygen Therapy: Executive summary from the Thoracic Society of Australia and New Zealand. Respirology 2016; 21: 76-78

REFERRING DOCTOR:
PROVIDER NUMBER:
DEPARTMENT:
ADDRESS:

PHONE:
FAX:
EMAIL:

**Home Care Subsidy – Oxygen Supplement**
**Commonwealth Department of Health Services**
**GPO Box 9923**
**Sydney NSW 2001**

DATE:

Dear Sir/Madam

Re: _____
**Patient Name**

The above named patient requires Domiciliary Oxygen Therapy from _____/_____/_____.
**Date**

This is a permanent / temporary prescription.

Yours sincerely,

_____
**Signature**

_____
**Referring Doctor Name**

**ATTENTION:** RESIDENTIAL AGED CARE FACILITY:
PLEASE KEEP A COPY OF THIS LETTER IN THE PATIENT'S FILE AND SEND THIS ORIGINAL TO THE ADDRESS ABOVE ALONG WITH THE CLAIM FORM, TO CLAIM REIMBURSEMENT OF THE COSTS OF THE OXYGEN.

https://www.humanservices.gov.au/organisations/health-professionals/forms/ac011