# Equipment Request Form

Use this form for Lifetime Care Scheme and the Workers Care Program

## ****1. Person’s information****

|  |  |  |  |
| --- | --- | --- | --- |
| **First Name** | **Last Name** | | **Participant No. or Claim No.** |
|  |  | |  |
| **Title** | | **Age** | |
|  | |  | |
| **Address** | | | |
|  | | | |
| **Phone** | | **Mobile** | |
|  | |  | |
| **Contact person (if not injured person)** | | **Contact details** | |
|  | |  | |
| **Injury** | | | |
| TBI | SCI - Specify level: | | Other (please specify): |

## ****2. Equipment Recommendation****

|  |  |  |  |
| --- | --- | --- | --- |
| **a) What is the equipment recommendation?** | | | |
| Hire | Purchase | | Other: |
| **If hire, please provide the dates of hire**  **From date:** | | **To date:** | |
| Click or tap to enter a date. | | Click or tap to enter a date. | |
| **b) What is the equipment group according to the Professional Criteria for Prescribers? (tick all that apply)** | | | |
| 1 | 2 | | 3 |

|  |  |  |  |
| --- | --- | --- | --- |
| c) Equipment – specific model and/or specifications required | Provider / Supplier Name and ABN eg Aidacare, Alter, Alpha Lifecare, Independent Living Specialists | Quantity | Cost (+GST and delivery) |
| **1.** |  |  |  |
| **2.** |  |  |  |
| **3.** |  |  |  |
| **4.** |  |  |  |
| **5.** |  |  |  |

### **d) Equipment provider panel**

|  |  |  |
| --- | --- | --- |
| **i) is the equipment from a panel provider?** | Yes | No |
| **ii) If no, give reasons why:** | | |
|  | | |
| **ii) Provide non-panel provider details including Name, Address, Phone Number and quote number** | | |
|  | | |

## ****3. Equipment justification****

|  |
| --- |
| **a) State the person’s goal/s that relate to the item/s of equipment** |
|  |
| **b) Describe the person’s need for this equipment. *Include relevant assessment results, functional abilities, prognosis, motivation, support, other equipment used or prescribed and environment(s).*** |
|  |
| **c) Please provide justification for the features/specifications of the recommended equipment** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| d) Compatibility with the person’s environment | | | |
| **i) Has the discharge destination been confirmed?** | Yes | No | N/A |
| **ii) Is the recommended equipment compatible with the environment(s) (including storage)?** | Yes | No |  |
| **iii) is the recommended equipment compatible with the current equipment being used?** | Yes | No | N/A |
| **iv) Is the equipment compatible with the person’s transport?** | Yes | No | N/A |
| **v) Is the person or other relevant users (e.g. family / support workers) capable of using the recommended equipment safely and appropriately? Including care, maintenance and troubleshooting.** | Yes | No |  |

|  |
| --- |
| **If no is ticked above please explain:** |
|  |
| **e) Trial of recommended equipment: *Describe duration, location and outcome of trial. If trial was not conducted provide details.*** |
|  |

f) Other equipment trialled or considered: *Include details of all other equipment trialled or investigated.*

|  |  |  |  |
| --- | --- | --- | --- |
| Equipment | Cost | Method of Evaluation  Trial = T Investigated = I | Outcome (provide reasons why not recommended |
|  |  | T  I  Loan |  |
|  |  | T  I  Loan |  |
|  |  | T  I  Loan |  |

|  |  |  |
| --- | --- | --- |
| **g) What are the potential risks for the person / carer / other users if this equipment is not provided?** | | |
|  | | |
| **h) What are the potential risks to the person / carer / others from the use of this equipment and how can these risks be mitigated?** | | |
|  | | |
| **i) How often will this equipment be used?** | | |
| Continuously / multiple times each day | 1 x daily | Several times weekly |
| 1 x a week | Other, provide details: | |
| **j) Is this person / guardian / carer aware of and in agreement with this equipment request?** | | |
| Yes | Date agreement received: Click or tap to enter a date. | |
| No, N.B Application will not be processed without agreement of the person / guardian / carer | | |
| **k) Has a copy of the equipment request been given to the person?** | | |
| Yes | No | Date equipment request has been given to the person: Click or tap to enter a date. |

## 4. Delivery information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **a) Who should be notified when the equipment is ready to be delivered?** | | | | |
| Prescriber | Prescribing team | | Other | Please provide contact email, phone or fax: |
| **b) Delivery address for equipment:** | | | | |
| Person’s home | | Other, give details: | | |
| **c) What set up / installation / customisation and training is required?** | | | | |
|  | | | | |

## 5. Prescriber Declaration

I declare that I have assessed the person and have the required qualification and level of experience to prescribe this equipment according to the Professional Criteria for prescribers.

This equipment has been prescribed by the treating multi-disciplinary team on Enter text. and I have completed the equipment request on behalf of that team.

I declare that I have been approved by icare to prescribe this category of equipment.

I declare that I have assessed the person and have been supervised by Enter text. who meets the Professional Criteria for prescribers and has agreed to be nominated as my supervisor for this prescription.

### Prescriber details

|  |  |
| --- | --- |
| **Name** | **Signature** |
|  | **Prescriber Signature** |
| **Address** | **Qualification** |
|  |  |
| **Phone** | **Days / hours available** |
|  |  |
| **ABN** | **Date** |
|  | Click or tap to enter a date. |
| **Email** | |
|  | |

### Supervisor details

|  |  |
| --- | --- |
| **Name** | **Signature of supervisor (if practical)** |
|  | **Supervisor signature** |
| **Address** | **Qualification** |
|  |  |
| **Phone** | **Days / hours available** |
|  |  |
| **Email** | **Date** |
|  | Click or tap to enter a date. |

|  |
| --- |
| **Once completed please e-mail this form to:**  [care-requests@icare.nsw.gov.au](mailto:care-requests@icare.nsw.gov.au)  **and include the following in the subject header:**  **Equipment Request [Participant/Worker reference number] [icare contact name]** |

|  |  |
| --- | --- |
|  | icare GPO Box 4052, Sydney, NSW 2001 **General Phone Enquiries: 1300 738 586** Fax: 1300 738 583 Email: [care-requests@icare.nsw.gov.au](mailto:care-requests@icare.nsw.gov.au) www.icare.nsw.gov.au |