# 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** |
|  |

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| --- |
| 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 EvaluationTrial = 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**and include the following in the subject header:**  **Equipment Request [Participant/Worker reference number] [icare contact name]** |

|  |  |
| --- | --- |
|  | icareGPO Box 4052, Sydney, NSW 2001**General Phone Enquiries: 1300 738 586**Fax: 1300 738 583Email: care-requests@icare.nsw.gov.auwww.icare.nsw.gov.au |