Equipment Request Form

NSW GOVERNMENT | HealthShare EnableNSW

1. CLIENT INFORMATION

Client Name	**Last Name** Blogs **First Name** Jo	**ENABLE #** ☒ Aids and Equipment Program ☐ SEED	
Title	☒ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other	**Date of birth:** 01-01-1965	
Address	1 Blogs Street Suburb Blogstown Postcode 2666		
Phone	0402 000 000	**Mobile**	0402 000 000

Contact person (if not client) Tom Blogs (brother)	**Contact details** 0411 111 111

Diagnosis (include date of injury)
Charcot Neuroarthropathy diagnosed 2010. Resultant destruction of mid foot joints, severe foot deformities.
Left total hip replacement 2011 resulting in limb length discrepancy of 30mm.

2. EQUIPMENT RECOMMENDATION

☐ **Hire** ☒ **Purchase** ☐ **ELP transfer** ☐ **Stock Equipment**

What category of equipment is being requested?
☐ ADL ☐ Communication & Technology ☐ Mobility & Transfers ☐ Nutrition
☒ Orthoses & Footwear ☐ Pressure Care ☐ Other

Equipment – specific model or specifications required	**Supplier details** (including quote #); **government contract # or ELP details**	**Qty/ Hire period**	**Cost (inc GST & Del)**	**Quote**
1. Custom footwear with medial flare, rigid heel counter and 27mm heel raise (L)	**Shoes R Us**	**1 Pair**	**$900**	**#111**
2. Custom foot orthoses to accommodate plantar foot deformities	**Orthotics R Us**	**1 Pair**	**$500**	**#222**
3.			**$**	
4.			**$**	
5.			**$**	

3. EQUIPMENT JUSTIFICATION

(a) State the client centred goal/s that relates to this/these items of equipment.
Walk more than 20 metres at a time to achieve household tasks and community access
Complete meal preparation without needing to sit down, reduce the need for carer assistance in completing household tasks

(b) What assessments were conducted in determining need for this equipment?

☐ ADL Assessment ☒ Functional Assessment ☐ Home Visit ☐ Community Visit
☐ Specific assessment List:

Name:
Date of Birth:

c) Describe the client's need for this equipment. *Include relevant assessment results, functional abilities, prognosis, motivation, support, other equipment used or being prescribed and environment/s*

Unable to walk more than 5 metres without severe pain and fatigue. Unable to feel 10g monofilament, resulting in need to re-distribute plantar pressures and accommodate severe Charcot deformities. Mid-foot joint degeneration, classic Rocker bottom sole deformity, very prominent bony protrusions with current ulceration, increased width of midfoot. Current ulceration and unable to use current footwear.

Unable to complete ADLs such as cooking meals as unable to stand for longer than 10 minutes; relies on home care staff to complete household tasks.

d) Describe how the features/specifications of the recommended equipment will meet the client's needs in the most cost effective, clinically appropriate way.

Shape of foot deformities prevents use of pre-fabricated orthoses- rocker bottom sole and presence of ulcers require custom plantar pressure re-distribution.

e) Compatibility with the client's environment.

Has the client's discharge destination been confirmed?	☐ Yes ☐ No ☒ N/A
Is the recommended equipment compatible with current equipment being used?	☐ Yes ☐ No ☒ N/A
Is the equipment compatible with the client's transport?	☐ Yes ☐ No ☒ N/A
Is the recommended equipment compatible with the environment/s (incl. storage)?	☒ Yes ☐ No
Is the client or other relevant users (carers / others) capable of using the recommended equipment safely and appropriately? Including, care and maintenance and troubleshooting.	☒ Yes ☐ No

If No, provide details:

f) Trial of recommended equipment: *Describe duration, location and outcome of trial. If trial was not conducted provide details*

Used pre-fab orthoses prior to Charcot diagnosis for comfort but did not provide enough support post joint degeneration and caused ulceration.

Has used prefabricated medical grade footwear (eg. Dr Comfort, etc) but can no longer accommodate width of mid foot. unable to trial custom made footwear, but is next progressiopn after pre-fabricated MGF does not meet needs

g) What are the potential risks for the client/ carer/ other users if this equipment is not provided?

Inability to mobilise safely, complete self-care tasks safely and particpate in household and community activities. Further ulceration, possible amputation

h) How often will this equipment be used?

☒ Continually or multiple times each day ☐ 1x daily ☐ 1 – 2 x weekly
☐ Other, provide details:

i) Other equipment considered Include details of all other equipment trialled or investigated.

Equipment	**Cost** (approx)	**Method of Evaluation** Trial = T Investigated = I	**Outcome** (Provide reasons why not recommended)
Prefab medical grade footwear	$600	☒ T ☐ I ☐ loan	Can no longer meet width requirements of feet
Rockports	$200	☐ T ☒ I ☐ loan	Can no longer meet width requirements of feet
	$	☐ T ☐ I ☐ loan	
	$	☐ T ☐ I ☐ loan	
	$	☐ T ☐ I ☐ loan	

j) Is the client/carer aware of and in agreement with this equipment request?
☒ Yes Date agreement received: 1-1-2013
☐ No N.B. Application will only be processed with client/carer agreement.

k) A copy of the equipment request given/sent to the client.
☒ Yes ☐ No If no, provide details

4. DELIVERY INFORMATION

☐ N/A - ELP equipment in place, funds transfer only

a) Who should be notified when the equipment is ready to be delivered?
☐ Prescriber ☐ Prescribing team ☒Client
☐ Other. Provide contact name, relationship, phone, email

b) Delivery address for equipment
☐ Client's home address
☒ Other, give details consumer to contact supplier to arrange appointment

c) Delivery Instructions ☐ Yes ☒ No
If yes, details:

5. EVALUATION PLANNING

a) Should an Equipment Evaluation Form (EEF) be completed once the client has used the equipment in the intended environment for 4 – 12 weeks?
☒ Yes ☐ No If No, indicate reason:

b) Who will complete the EEF?
☒ Prescriber ☐ Prescribing team
☐ Other professional. Provide contact details:

Has a copy of the equipment request form been provided to the professional or service who will be completing the Equipment Evaluation Form? ☒ Yes ☐ No

c) What is the recommended method of completing EEF?
☒ Home visit / clinic appointment ☐ Telephone call ☐ Other

6. PRESCRIBER DECLARATION

Referring to the EnableNSW and LTCSA Professional Criteria for Prescribers, what is the equipment group?
Tick all that apply.
Group ☐ 1 ☐ 2 ☒ 3

DECLARATION

☒ I declare that I have assessed the client 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
and I have completed the equipment request on behalf of that team. Team included:

☐ I declare that I have assessed the client and that I am approved by my service to prescribe this Group 1 equipment.
Name of service

☐ I declare that I have assessed the client and have been supervised by
who meets the Professional Criteria for Prescribers to prescribe this equipment and has agreed to be nominated as my supervisor for this prescription.

☐ I declare that I have assessed the client and am an Approved Prescriber of this group of equipment.

Prescriber name, name of service, address, phone, email:	Signature:
Dr Foot 1 Foot Street	Qualification: AFRM
	Days/Hours available: M-F 9-5

Name:
Date of Birth:

Footsville, 2222 (02) 2222 2222 drfoot@footsville.com.au	Date: 01-01-2013
Supervisor name, name of service, address, phone, email: (if required)	Signature of supervisor (if practical):
	Qualification:
	Days/Hours available:
	Date:

NB: Incomplete forms will be sent back. Please ensure all contact details are provided.