Stock Equipment Request Form

Please note that a consumer application is also required and that a co-payment applies.

HealthShare EnableNSW

☐ New Request ☐ Amended Request
Mark if applicable: ☐ SEED ☐ Statewide Paediatric Equipment ☐ PWC Allocation Program

1. PERSONAL INFORMATION

Title	Last name First name	Address Suburb & Post Code	Date of birth:

Phone		Mobile	

Alternative contact person	Relationship	Contact details

Diagnosis (relevant to this request):	Other medical/health conditions that relate to this request:

Has the person's discharge date and destination been confirmed? ☐ Yes ☐ No ☐ N/A
Discharge date: If no, please provide details:
Discharge destination ☐ Home ☐ Other, please specify

2. STOCK ITEMS REQUESTED

If requesting 2 items of the same equipment type, list these here. EnableNSW will arrange for the 2nd item to be collected.

Part number *(Mandatory)*	Equipment description *(include Asset # if applicable)*	Replacement item?	Pick up old item?
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No

Frequency of use of equipment – ☐ Daily ☐ Weekly
Safety - Person's weight: Is person's weight within the safe working load (SWL) of this equipment? ☐ Yes ☐ No
If a requested item is unavailable, would you like to be contacted if alternate item available? ☐ Yes ☐ No

3. IDENTIFICATION OF NEED

a) **Goal of Equipment provision:** *(Tick all that apply)*
Improved safety and/or independence for person and/or carer with:
☐ Self-care tasks ☐ Transfers ☐ Pressure Management (Please also complete **Section 4**)
☐ Mobility within the home ☐ Mobility in the community

b) **Person's current physical function:** *(Tick all that apply)*

Ambulant Mobility within the home:
☐ walks with no aids. Distance m
☐ walks with aids. Distance m
☐ unable to walk

Seated mobility: ☐ N/A
☐ independent with: ☐MWC ☐PWC ☐scooter
☐ attendant propelled: ☐ MWC ☐ PWC ☐ stroller

Ambulant Mobility outside the home/in community:
☐ walks with no aids. Distance m
☐ walks with aids. Distance m
☐ unable to walk

Postural support:
☐ sits independently
☐ sits upright with trunk support
☐ tilt required to maintain trunk and head upright
☐ fixed postural deformities

Transfers:
☐ independent with/without aids
☐ assisted standing/slide transfers
☐ lifted/hoisted

If requesting a hoist, is this being used for transfers post falls? ☐ Yes ☐ No

Self-care:
☐ independent with/without aids
☐ requires supervision / set up
☐ requires minimal assistance
☐ requires full assistance

c) Are you requesting a King Single or Floorline bed? ☐ Yes ☐ No

If yes, please provide reasons that a single bed does not meet the person's clinical needs:

d) Compatibility

Is the recommended equipment compatible with current equipment being used? ☐ Yes ☐ No ☐ N/A

Is the recommended equipment compatible with the person's transport? ☐ Yes ☐ No ☐ N/A

Is the recommended equipment compatible with the home environment? ☐ Yes ☐ No

Is the person or other relevant users (carers/others) capable of using the recommended equipment safely and appropriately? Including, care and maintenance and troubleshooting. ☐ Yes ☐ No

Provide details if no to any of the above:

4. EQUIPMENT JUSTIFICATION for pressure cushions, static air or alternating air mattresses.

Is there a current pressure injury or history of pressure injuries:

☐ Yes ☐ No

If yes, provide information regarding the stage, duration and date of occurrence of pressure injuries:

Pressure Risk Assessment Tool - Risk Level:

Tick one:

☐ Braden/Braden Q ☐ Norton

☐ Waterlow ☐ Other:

Describe ongoing risk of pressure issues once management strategies have been implemented and the acute stage has been resolved:

Describe how the features/specifications of the recommended pressure cushion/pressure relieving items will meet the person's ongoing pressure care needs:

5. DELIVERY INFORMATION

(a) Who should be notified when the equipment is ready to be delivered?

☐ Person ☐ Alternative contact person

☐ Other, provide contact name and details:

(b) Delivery address for equipment

☐ Person's home address

☐ Other, give details:

(c) PWC Allocation, please nominate supplier (from approved list):

NB: Send seating quote (if required) to HSNSW-enableEAP@health.nsw.gov.au once confirmed, following trial.

6. PRESCRIBER DECLARATION *(Tick all that apply)*

☐ I confirm that the person/carer is in agreement with this request :

A copy of this request has been provided to person/carer ☐ Yes ☐ No

☐ I understand that all information I have supplied on this application is true and correct to the best of my knowledge at the time of assessment.

☐ 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. OR

☐ I declare that I have assessed the person and I have been supervised by who is an eligible prescriber and has agreed to be nominated as my supervisor for this prescription.

☐ I have read and understand my responsibilities and obligations as provided in the declaration above.

Prescriber name:	*If applicable:*
Qualification:	Supervisor name:
AHPRA Registration Number:	Qualification:
Phone:	AHPRA Registration Number:
Email:	Phone:
Name of Service:	Email:
Days/Hours available:	Name of Service:
	Days/Hours available:

Date submitted: