EnableNSW

Blindness and Low Vision Equipment Request Form

When to use this form

Use this form if you cannot submit this request using EnableNSW Online.

Find out more at www.enable.health.nsw.gov.au/online

Filling in this form

You can complete this form on your computer or print and sign it. If you need to print this form ensure you:

- Use blue or black pen
- Print in BLOCK LETTERS
- Sign the prescriber declaration

Eligibility

An EnableNSW application form is required to assess a person's eligibility. A new application form is required every two years **OR** if the person's circumstances change. Application forms can be accessed online at www.enable.health.nsw.gov.au/for_individuals/applying-to-EnableNSW. If we do not have an application form at the time of reviewing this request, the request may go on hold and delay the outcome.

Important information before making this request

- You must be an eligible prescriber for this type of equipment **AND**,
- the equipment requested must meet the applicable funding criteria. You can read more about this at www.enable.health.nsw.gov.au/prescribers/forms
- You must attach a quote to this form for the equipment you are requesting.

For more information

Go to our website www.enable.health.nsw.gov.au or call us on 1800 Enable (1800 362 253)

Privacy

We collect your personal information and the health information of patients to allow EnableNSW to manage and provide its services. This allows us to:

- Assess your eligibility to prescribe assistive technology in accordance with the relevant funding criteria
- Contact you if more clinical information is required about the request, as well as provide status updates about the request
- Share contact details with a supplier if additional support is required for set up of equipment when necessary.

If you would like to view or make changes to your information, please send an email to enable@health.nsw.gov.au or call 1800 Enable (1800 362 253).

A. Request type

☐ New request ☐ Amendment to existing request

B. Person information

1. Person details

Title ______ First name ______ Surname ______

Date of birth DD/MM/YYYY

Medicare card number ☐☐☐☐ ☐☐☐☐☐ ☐ Ref no. ☐

Person's address ______

State ______ Postcode ______

2. Delivery details

Confirm the supplier/prescriber will contact the person/carer for appointments ☐

Where will the equipment be delivered to? *Select ONE only*

☐ Person's address

☐ Other, please specify where the equipment will be delivered / confirm the person's hospital or TCP discharge date ______

Contact name ______ Contact phone number ( )

Delivery address (if not person's address) ______

State ______ Postcode ______

Is there equipment that needs to be collected? *Select ONE option*

☐ Yes ☐ No

C. Diagnosis

3. **What is the primary diagnosis in relation to the requested equipment?**

4. **Provide other relevant diagnosis/co-morbidities**

D. Equipment category

5. **What equipment are you requesting?** *Select ONE option*

- ☐ Camera-reading glasses
- ☐ Desktop Magnifier
- ☐ Portable Magnifier
- ☐ Other Blindness and low vision aid

6. **For replacement requests complete the following:** *Select N/A if new request*

- ☐ N/A – This equipment has not been previously funded by EnableNSW
- ☐ Current equipment is no longer clinically appropriate
- ☐ Current equipment is beyond repair and unsafe to use
- ☐ Current equipment is due for replacement due to general wear and tear
- ☐ Other – provide details below

E. Equipment recommendation

7. **Provide brand/model, supplier details, price and an itemised quote for the requested equipment:**

Note you must attach a quote for all items in this request

Equipment – specifications required	Preferred supplier details	Qty	Cost (inc GST & delivery)	Quote number
			$	
			$	
			$	
			$	
			$	

8. **Confirm the requested equipment complies with the relevant Australian or International Standards and/or has Therapeutic Goods Administration (TGA) registration (class 1 medical devices):** *Select ONE option*

- ☐ Yes
- ☐ No

F. Equipment goals

9. **What regularly occurring core (text or other visually based) activities does the person require the requested technology to complete independently?** *Select all that apply*

- ☐ Reading and writing personal correspondence (e.g. utility and other bills)
- ☐ Computer access for core tasks such as banking and shopping
- ☐ Managing medications, meal time preparations , reading recipes and food labels

10. **For Electronic Magnifier with Optical Character Recognition (OCR) requests please confirm ALL of the following:**

- ☐ N/A – I am not requesting an electronic magnifier with OCR
- ☐ The person requires the technology to read magnified text without significant eye strain or tiredness
- ☐ The person requires additional text to speech function to complete tasks

11. **For Portable and/or wearable Text to Speech device requests confirm the following:**

- ☐ N/A – I am not requesting a portable or wearable text to speech device
- ☐ The person requires a portable/wearable device to meet their accessibility goals

12. **For Deaf-blind communication device requests confirm the following:**

- ☐ N/A – I am not requesting a deaf-blind communication device
- ☐ The person has a demonstrated need for the device and it will be used daily for functional communication
- ☐ The person has the required level of literacy and cognitive skills to use the device

13. **For Audio monitors (BSL and BP) requests confirm the following:** *Select ALL that apply*

- ☐ N/A – I am not requesting an audio monitor
- ☐ The person requires the device to monitor their blood pressure on a daily basis (please attach letter from their Medical Practitioner)
- ☐ The person lives alone and has no one to assist with their blood pressure monitoring
- ☐ The person lives alone and has no one to assist with their blood sugar level monitoring

G. Equipment justification

14. **Describe the person's impairment related to the requested device (may include near/distance vision, preferred size of print, glare sensitivity, visual fatigue, visual fields, contrast sensitivity, and colour vision):**

Provide detail and attach supporting documentation if required

15. **Describe how the features of the equipment requested are going to support the person's functional needs:**

H. Trial outcomes

16. **Was a trial of the requested equipment completed?** *Select ONE option*

Note: A trial is required for all items in this category

- ☐ Yes - provide detail of trial outcomes related to stated goals below
- ☐ No - provide information why a trial was not completed below

17. **What other blindness and low vision equipment was trialled?** *List all other equipment trialled including the outcome*

I. Compatibility

18. Confirm the equipment is compatible with the: *Select all that apply*

- ☐ Current equipment being used
- ☐ Environment of use

J. Safe use, care and maintenance

19. Confirm the person and/or family/carer will receive education in the: *Select all that apply*

- ☐ Safe use of the requested equipment
- ☐ Correct care and maintenance of the requested equipment

Go to next page and complete Section K. Prescriber Eligibility and Declaration

K. Prescriber eligibility and declaration

20. Prescriber eligibility

Confirm you have assessed the person and have the qualification and level of experience to prescribe this equipment in line with the relevant EnableNSW Funding Criteria and Professional Criteria for Prescribers.

☐ Yes ***Go to question 21***

☐ No – I do not have the level of experience to prescribe this type of equipment as required by the funding criteria.

The assessment of the person and equipment request has been supervised by an eligible EnableNSW prescriber.
Provide your supervisor's name and email address

Supervisor's name ________ Supervisor's email ________

21. Prescriber declaration

I confirm the following:

- The person/carer agrees with this request
- A copy of this request will be provided to the person/carer
- As a health professional, I cannot also be the equipment supplier for the same request. This may include but is not limited to a personal or professional relationship with or material interest in the supplier or manufacturer of the equipment listed on this request

I declare that:

- I have the qualification and experience to prescribe this equipment and am an accredited prescriber with EnableNSW.
- All information I have supplied on this application is true and correct to the best of my knowledge at the time of assessment

Prescriber information:

Prescriber name ________

Place of work ________

Address ________

________ State ____ Postcode ____

Qualification ________ AHPRA registration number ________

Phone number ( ) ________ Email ________

Signature ________ Date DD/MM/YYYY

22. Other contacts (optional)

Complete this question if you would like to provide details of any other relevant health professionals who will be involved with the management and monitoring of the person's condition

Other contact 1

Name ________

Place of work ________

Address ________

________ State ____ Postcode ____

Qualification ________ AHPRA registration number ________

Phone number ( ) ________ Email ________

Other contact 2

Name ________

Place of work ________

Address ________

________ State ____ Postcode ____

Qualification ________ AHPRA registration number ________

Phone number ( ) ________ Email ________

Submitting this request

Submit this form and any relevant clinical documentation to enable@health.nsw.gov.au, please include the following in your subject line **Equipment type_Person name_Date submitted** *i.e Blindness and low vision equipment_John Smith_01.01.2022*