# EnableNSW
# Wigs
# 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, 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 product or item 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 product 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

## B. Person information

**1. Person details**

Title ☐ First name ☐ Surname ☐

Date of birth D D/M M/Y Y Y Y

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

Person's address ☐

☐ State ☐ Postcode ☐

**2. Delivery details**

Where will the products be delivered to? *Select ONE option*

☐ Person's address ***Go to question 3***

☐ Other, please specify where the products will be delivered ☐

Contact name ☐ Contact phone number ( )

Delivery address (if not person's address) ☐

☐ State ☐ Postcode ☐

## C. Diagnosis

**3. What is the primary diagnosis in relation to the request for a wig?**

- ☐ Alopecia areata totalis
- ☐ Alopecia areata universalis
- ☐ Lichen Planus
- ☐ Skin graft - at least 40% permanent hair loss
- ☐ Other – specify in text box

## D. Equipment category

**4. Select type of wig and provide supplier details, price and quote for the recommended wig**

*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 |
|---|---|---|---|---|
| ☐ Synthetic wig<br>☐ Human hair wig<br>☐ Combination synthetic/ human hair wig | | | $ | |

## E. Identification of need - goals

**5. Confirm the hair loss is permanent AND select the goals that apply while wearing the wig:** *Select all that apply*

- ☐ To cover permanent loss of hair
- ☐ To improve social inclusion
- ☐ To improve quality of life
- ☐ To improve body image

**6. How often will the wig be worn?** *Select ONE option*

- ☐ Continuously every day
- ☐ Other - specify in text box

## F. Equipment justification

**7. Select ONE of the diagnostic groups below based on the person's diagnosis and complete the relevant section**

☐ **Alopecia totalis/universalis, Lichen planus/planopilaris and/or other**

**8. Date hair loss first observed:** *provide an approximate date if exact date unknown*

**9. Has the condition been diagnosed/confirmed by a medical specialist?** *(e.g. Dermatologist or Endocrinologist)*

- ☐ No
- ☐ Yes - provide additional details including specialist's name and profession

**10. Has the person received treatment for their hair loss?**

- ☐ Yes - describe the treatment received and the outcome below
- ☐ No - provide reasons below

**11. Specify percentage of hair loss**

☐ **Skin graft**

**12. Provide date of onset/surgery:** *provide an approximate date if exact date unknown*

**13. Specify percentage of hair loss**

**14. Has the person worn a wig before?** *Select ONE option*

☐ Never worn a wig before

☐ Worn a wig before funded by EnableNSW

☐ Worn a wig before not funded by EnableNSW

## G. Wig provision, care and maintenance

**15. Confirm ALL of the following:**

☐ Person/carer is aware of funding allocation and replacement period for wigs, provided by EnableNSW

☐ Person/carer is aware that EnableNSW does not reimburse for privately purchased items

☐ Person/carer understands how to care and maintain wig

☐ Person/carer understands that cost of care and repairs is at their own expense

***Go to next page and complete Section H. Prescriber Eligibility and Declaration***

## H. Prescriber eligibility and declaration

**16. 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

**17. 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 or, I have been supervised by an eligible EnableNSW prescriber for this type of equipment
- 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 | D D/M M/Y Y Y Y |

**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 Wig_John Smith_01.01.2022*