NSW GOVERNMENT

EnableNSW Compression Garment 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, including completion of a Level 1 Lymphoedema Training Course, recognised by the Australasian Lymphology Association **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 include the relevant contract code for the product you are requesting. If you are requesting an item not available through contract or a custom item from contract, you must attach a quote to this form

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.

A. Request type

☐ New request ☐ Exact re-order ☐ Change in clinical prescription for the next order

☐ Amendment to existing request - *specify date the existing request was submitted*

What compression garments are you requesting: *Select all that apply*

☐ Upper limb Compression Garment

☐ Lower Limb Compression Garment

☐ Other Compression Garment

Date of assessment/ for this equipment D D/M M/Y Y Y Y

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**

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

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

☐ Person's address

☐ Other, please specify where the equipment will be delivered

Contact name | Contact phone number ( )

Delivery address (if not person's address)

State | Postcode

If applicable, confirm the person's hospital or TCP discharge date D D/M M/Y Y Y Y

3. **Does the person need to be re-measured once funding is approved?** *Select ONE option*

☐ Yes - prescriber to be informed when the order is placed

☐ No - place order as re-measure is not required

C. Diagnosis

4. **What is the primary diagnosis in relation to the requested compression garments?**

5. **Select the specific diagnosis related to the need for compression garments:** *Select all that apply*

☐ Lipoedema ☐ Lymphoedema ☐ Lymphoedema – primary ☐ Lymphoedema – secondary ☐ Venous insufficiency

6. **How severe is the person's lymphoedema:** *Select ONE option*

☐ Mild ☐ Moderate ☐ Severe

7. **Indicate the affected area/s:** *Select all that apply*

☐ Left upper limb
☐ Right upper limb
☐ Left lower limb
☐ Head and neck
☐ Right lower limb
☐ Chest
☐ Back
☐ Abdomen
☐ Buttocks
☐ Breast
☐ Genital

8. **Provide date of onset of lymphoedema / lipodema / venous insufficiency:**
Provide an approximate date if exact date unknown D D/M M/Y Y Y Y

D. Equipment recommendation

9. **List the requested compression garments, including delivery options and attach an itemised quote if relevant**

Product code	Description * RTW = Ready to wear			Supplier	Quantity Each	Pair	Cost	Contract / Quote #
		RTW ☐	Custom ☐				$	
		RTW ☐	Custom ☐				$	
		RTW ☐	Custom ☐				$	
		RTW ☐	Custom ☐				$	
		RTW ☐	Custom ☐				$	
Will two (2) deliveries be required for this order? (If a second delivery is required to ensure correct fit, please ensure cost is included in the quote)							Yes ☐	No ☐
TOTAL COST							$	

- Specify quantity and cost per affected body part per 6 months
- New quote is required every 6 months if applicable. Quantities / Quote should reflect order for 6 months
- Indicate cost per garment or per pair of garments

10. **For ALL non-contract compression garments confirm compliance with the relevant Australian or International Standards and/or has Therapeutic Goods Administration (TGA) registration (class 1 medical devices):** *Select ONE option*

- [ ] N/A – I have selected contract equipment
- [ ] Yes
- [ ] No

E. Equipment goals

11. **Confirm the person requires compression garments to assist with:** *Select all that apply*

- [ ] Reducing and maintaining swelling and other lymphoedema symptoms
- [ ] Completing activities of daily living
- [ ] Wearing clothes and dressing independently
- [ ] Wearing footwear
- [ ] Mobilising safely
- [ ] Bed mobility and transfers
- [ ] Reducing the risk of falls

F. Equipment justification

12. **Confirm the person's:** *Select all that apply*

- [ ] Oedema is stable
- [ ] Swelling is minimised
- [ ] Pitting oedema is absent or minimal
- [ ] Shape distortion has been optimized

13. **Confirm the person will wear the compression garments:** *Select all that apply*

- [ ] Every day
- [ ] Every night
- [ ] Other – specify wearing regime if garments are not worn every day and / or night

14. **Confirm the person and / or carer:** *Select all that apply*

- [ ] Is compliant with wearing the requested compression garments
- [ ] Is able to don/doff the requested garments

15. **Are you requesting contract ready-to-wear (RTW) compression garments:** *Select ONE option*

- [ ] Yes – ***go to question 18***
- [ ] No - I am requesting contract custom-made garments – ***Go to question 16***
- [ ] No - I am requesting non-contract garments (RTW or custom made) – ***Go to question 17***

16. **Provide clinical justification for contract custom-made garments, including outcome of garment trials**

17. **Provide additional clinical justification why contract garments do not meet the person's specific clinical need and provide detail of trial outcomes of requested non contract compression garments**

18. For ALL requests where multiple garments are ordered for one affected area, describe individual pieces worn and/or layered as one set *Type N/A if not applicable or an exact reorder is being requested*

G. Trial outcomes

19. Has the prescribed compression garment/s been successfully trialled: *Select ONE option*

☐ Yes-the garments are effective in managing the oedema

☐ Yes – current EnableNSW compression garment consumer requesting an exact reorder

☐ No

20. Provide details of trial including duration and describe how each feature/specification of the recommended compression garment/s will meet the person's needs. *Type N/A if not applicable or an exact reorder is being requested*

21. What other compression garments has the person previously trialled - include type, compression class, other garment features (e.g. zips) etc *Type N/A if no other garments trialled or an exact reorder is being requested*

H. Safe use, care and maintenance

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

☐ Safe use of the requested compression garments

☐ Correct care and maintenance of the requested compression garments

☐ Clinical follow up / assistance plan including local lymphoedema clinician contact details

☐ EnableNSW compression garment allocations and process for future funding requests

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

I. Prescriber eligibility and declaration

23. 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 24***

☐ 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 ________

24. 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 DD/MM/YYYY

25. 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 Compression-garment_John Smith_01.01.2022*