NSW GOVERNMENT

EnableNSW
Environmental Control System (ECS) 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 informatio
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

Date of assessment/review 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

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

☐ 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

If applicable, provide any special delivery instructions

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*

☐ Environment Control System (ECS) ☐ ECS accessories

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

☐ NA – This equipment has not been funded previously by EnableNSW
☐ Current prescription 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

E. Equipment recommendation

7. Provide brand/model, supplier details, price and an itemised quote for the Environment Control System

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. Confirm the person requires the ECS equipment to: *Select all that apply*

☐ Manage health and disability related activities of daily living e.g. carer scheduling, managing appointments, communication with health agencies
☐ Control their home environment e.g. temperature regulation, turning lights on and off, access to rooms, access to telephone
☐ Complete personal organisation e.g. accessing computer for banking and money management, essential shopping, personal correspondence
☐ Access their home environment e.g. opening and closing front door

G. Equipment justification

10. What does the person currently use for environmental control and what are the concerns with the existing set-up?

11. Describe alternative methods considered/trialled and the outcome, including commercially available ECS options (e.g. IR, bluetooth, apps, home automation etc):

12. Confirm the requested ECS equipment and accessories is the primary system to complete ADLs: *Select ONE option*

- ☐ Yes
- ☐ No

13. How frequently will the equipment be used? *Select ONE option*

- ☐ Continually or multiple times each day
- ☐ Once per day
- ☐ 1-2 times a week

14. Provide clinical justification for the requested equipment and its features that meet the person's need, including the multidisciplinary team input (i.e. specialist service), details such as level of independence achieved, what can the person do with/without the equipment – *attach additional documentation if required.*

H. Trial outcomes

15. Confirm a trial was completed, including demonstration of the person's capability to learn and operate the requested system: *Select ONE option*

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

- ☐ Yes – provide detail of trial outcomes below
- ☐ No – *provide information why a trial was not completed below*

I. Compatibility

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

- ☐ Current equipment being used
- ☐ Environment of use

J. Safe use, care and maintenance

17. 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
- ☐ Backup/emergency plan in the event of system failure
- ☐ Ongoing support and education

18. Confirm the person is aware that installation costs, including electrical or telephone outlets and electrical wiring are not included and will need to be self-funded

- ☐ N/A
- ☐ Yes
- ☐ No

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

K. Prescriber eligibility and declaration

19. 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 20***

☐ 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

20. 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 D D/M M/Y Y Y Y

21. 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 ECS equipment_John Smith_01.01.2022*