EnableNSW Continence 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 include the contract product code or manufacturer product code for all items 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 for next order

Provide date of assessment 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

If applicable, confirm the person's discharge date and discharge location if currently an admitted patient (hospital or TCP)

☐ N/A – the person is not an inpatient

Discharge date D D/M M/Y Y Y Y

Discharge location *Select ONE only*

☐ Person's address

☐ Other, specify ____

C. Diagnosis

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

4. Provide other relevant diagnosis/co-morbidities

5. Select Bladder and/or Bowel Diagnosis *Select all that apply*

☐ Urinary incontinence ☐ Faecal incontinent ☐ Bladder dysfunction

6. Does the person have permanent and moderate to severe incontinence? *Select ONE option*

☐ Yes ☐ No -provide detail in text box below

7. What products are you requesting? *Select all products being requested*

☐ Bed Pad ☐ Nappy/pull ups ☐ Urinary catheter accessories
☐ Irrigation accessories ☐ Pads/underwear ☐ Urinary catheter intermittent
☐ Irrigation system ☐ Sheaths ☐ Urinary drainage bags
☐ Urinary catheter indwelling

8. Provide product name, and manufacturer product code for all items requested

Actual allocation may vary depending on packaging. Please see Funding Criteria for maximum allocation provided and required clinical justification for a non-standard supply

For amended requests please indicate the items to be deleted and the new items to be added

Add	Del	Product name	Contract/ Manufacturer product code	Supplier (for non-contract products)	Standard allocation (per year)	Qty requested (if not standard)
		Urinary or faecal incontinence				
☐	☐	Pads/Pullups/Slips/Nappies			☐ 810 or ☐ 18 ☐ 270 or ☐ 2 reusable	
☐	☐	Washable Pads/garments				
☐	☐	Sheaths/Uridomes				
		Urinary and faecal incontinence				
☐	☐	Pads/Pullups/Slips/Nappies			☐ 1080 or ☐ 24	
☐	☐	Washable pads/garments				
☐	☐	**Reusable/washable bed pads**			☐ 3	
		Bladder dysfunction				
☐	☐	Intermittent catheters (standard)			☐ 600 ☐ 9 or ☐ 9 catheters (includes 3 sets)	
☐	☐	Indwelling or suprapubic catheters				
☐	☐	Reusable catheter sets				
		Drainage equipment				
☐	☐	Leg bags			☐ 36 disposable or ☐ 2 reusable	
		PLUS				
☐	☐	Drainage bags			☐ 36 disposable or ☐ 2 reusable	
☐	☐	Drainage bottles			☐ 36 disposable or ☐ 2 reusable	
☐	☐	Single use drainage bags without tap			☐ 270	
		PLUS				
☐	☐	Drainage tubes			☐ 6	
☐	☐	Catheter valves			☐ 9	
☐	☐	Catheter/thigh straps **OR**			☐ 4 standard or ☐ 2 deluxe	
☐	☐	Adhesive catheter stabilisation devices			☐ 1 box	
☐	☐	**Bowel management** *Contact EnableNSW for further information regarding allocations*				

D. Identification of need – goals

9. What goals will the requested continence products support? *Select all that apply*

- ☐ Maintain renal health
- ☐ Maintain skin integrity
- ☐ Prevent leakage
- ☐ Support social inclusion
- ☐ Other - provide details

E. Equipment justification

10. Does the person receive CAPS funding? *Select ONE option*

- ☐ Yes
- ☐ No – provide details in the text box below

11. What assessments were conducted in determining the need for this equipment? *Select all that apply*

- ☐ Bladder assessment
- ☐ Indwelling catheter assessment
- ☐ Bowel assessment
- ☐ Neurogenic bladder/bowel assessment
- ☐ Other - provide details

F. Equipment justification - Pads/slips/pullups for a person 5 years or older

12. Are you requesting pads/slips/pullups for person 5 years or older?

- ☐ No ***Go to question 13***
- ☐ Yes – confirm how many items the person uses in a 24 hour period

G. Equipment justification - Pads/slips/pullups for a person 4 years old

13. Are you requesting pads/slips/pullups for a person 4 years or younger?

- ☐ No ***Go to question 16***
- ☐ Yes

14. Does the child have a neurogenic bladder and bowel due to a neurological condition?

- ☐ No
- ☐ Yes – provide details in text box below

15. Has a toilet training program been undertaken?

- ☐ No - provide further detail on the impact of the child's disability or related health conditions on their ability to commence a toilet training program
- ☐ Yes - provide outcomes of participation in a toilet training program over a 6 month period

Provide supporting documentation from child's early intervention team/child care centre/school to demonstrate outcomes

H. Equipment justification - Catheter

16. Are you requesting catheters?

☐ No ***Go to question 19***

☐ Yes - provide frequency of catheterisation (how many catheters used in a 24 hour period)

17. If you have selected a non-standard contract catheter - provide clinical information regarding the need for this catheter/s

Include description of clinical outcomes when using standard catheters, include frequency of urinary infections/trauma/strictures or other issues experienced. Type N/A if not applicable

18. Provide name and details of medical specialist/continence advisor requesting products if not prescriber

Attach supporting documentation from medical specialist/continence advisor. Type N/A if not applicable

I. Equipment justification - Bowel management equipment

19. Are you requesting bowel management equipment?

☐ No ***Go to question 21***

☐ Yes, confirm ALL of the following:

- ☐ The person has an anal sphincter deficit or neurological incontinence
- ☐ The person is on a bowel washout regime with previous product trialled or replacement of product previously used
- ☐ The person is committed to ongoing out-of-pocket expenses to maintain bowel management program

20. Provide name and details of medical specialist/Continence CNC requesting products

Attach supporting documentation from medical specialist/continence advisor. Type N/A if not applicable

J. Equipment justification - ALL other products

21. List and provide clinical justification for any other products/accessories not specified above, include required allocation and clinical justification if a higher allocation is requested

K. Equipment justification - Non-Contract Products

22. Are you requesting a non-contract item?

☐ No ***Go to question 24***

☐ Yes - provide details why contract products do not need the person's specific needs.

23. What contract items have been trialled?

List full name of product, duration, outcome of trial and clinical reason why this item is not clinically suitable

L. Equipment justification - Allocation

24. Are you requesting a split allocation? *May be required when a person requires different products in the same equipment category*

- ☐ No
- ☐ Yes - provide detail of the split of products and clinical justification in text box below *(attach supporting documentation from medical specialist/continence advisor if relevant)*

25. Are you requesting a higher allocation?

- ☐ No
- ☐ Yes – specify allocation including clinical justification for the requested allocation.

M. Confirmation

26. Confirm the following:

- ☐ Person/carer is aware that there are maximum allocations through EnableNSW and how they can purchase additional supplies if required.
- ☐ Person/carer has received instructions on use and care of equipment/products
- ☐ Person/carer has details of local contact for ongoing clinical management if being discharged to another area
- ☐ If person is being discharged to another area for ongoing management provide name and details of local contact

N. Trial Outcomes

27. Has the person trialled the recommended product/s: *Select ONE option*

- ☐ Yes – provide the duration of the trial and how many items were trialled?
- ☐ No - provide details why the product/s were not trialled?

Go to next page and complete Section O. Prescriber eligibility and declaration

O. Prescriber eligibility and declaration

28. 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

29. 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

30. 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 Continence_John Smith_01.01.2022*