EnableNSW
Personal Alarm 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

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 option*

☐ Person's address

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

Contact name/relationship to the person ☐

Contact phone number ( )

Delivery address (if not person's address) ☐

☐ State Postcode

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?

☐ Personal emergency alarm system

6. Provide brand/model, supplier details, and price for non-monitored or monitored (set up fee only) personal alarm / alerting 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
			$	
			$	

7. For ALL requests, confirm compliance with the relevant Australian or International Standards and/or has Therapeutic Goods Administration (TGA) registration (class 1 medical devices)

☐ Yes ☐ No

E. Equipment goals

8. Confirm the person requires the personal alarm/alerting system equipment: *Select all that apply*

☐ To alert their nominated family/carer or emergency services in the event of a fall or medical emergency

☐ As they live alone or regularly spend periods of time at home alone and are unable to alert a carer of an emergency by other means

F. Equipment justification

9. Confirm the following: *Select all that apply*

☐ The person is at high risk of falls or has a history of falls in the last 12 months - provide details below

☐ The person has a high risk of medical emergency or a history of medical emergency at home - provide details below

☐ The person lives alone or regularly spends extended periods of time alone at home - provide details including duration and frequency below

☐ Person has the physical and cognitive ability to use the device

☐ Other risk mitigation strategies have been considered and implemented in addition to the requested personal alarm to manage falls and/or medical emergencies such as home modifications, provision of self-care equipment or falls risk education including environmental adjustments – please list below

G. Safe use, care and maintenance

10. 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
- ☐ Need to fund ongoing fees such as: Yearly SIM card replacement (for non-monitored alarms)
- ☐ Ongoing monitoring/rental fees (for monitored alarms)
- ☐ A plan for education / training on set up and correct use of the system is in place
- ☐ An emergency plan or alternate system is in place in the event of a breakdown

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

H. Prescriber eligibility and declaration

11. 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 12***

☐ 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 _____

12. 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

13. 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 *Personal Alarm_John Smith_01.01.2022*