## Adults with Chronic Conditions Registration Form

Please note: This form only needs to be submitted once at initial referral

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| Client Details | | | | | | **Date:** | | | |
| Phone | | | | | | Date of Birth | | | |
| Prefix | Last name | | | First Name | | | | Preferred Name | |
| Gender  M  F  Gender Diverse  Not stated | | | | | | | | | |
| Email | | | | | | Client Weight | | | |
| Residential Address | | | | | | | | | |
| Suburb | | | | | | Postcode | | | |
| Indigenous Status:  Aboriginal  TSI  Aboriginal and TSI  Neither  Not stated | | | | | | | | | |
| CALD Status:  Yes  No  Not stated / inadequately described  Cultural background/ language: Interpreter required:  Yes  No | | | | | | | | | |
| ALERTS: | | | | | | | | | |
| **Alternate contact** (if applicable)  Guardian  Other | | | | | | Preferred contact?  Y  N | | | |
| Name | | | | | | | Relationship | | |
| Phone | | | | | | | Email | | |
| Referrer Details | | | | | | | | | |
| Name | | | | | | Relationship to client | | | |
| Organisation       Profession | | | | | | | | | |
| Organisation Address | | | | | | | | | |
| Suburb / town | | | | | | Post Code | | | |
| Email | | | | | | Phone | | | |
| Signature | | | | | | Date | | | |
| **Referral Pathway** | | | | | | | | | |
| GP (Evidence of GPMP to be provided with registration form):  SA Health – Community Palliative Service. Specify which service:  SA Health – Chronic Disease Service / ICS. Specify which service:  DHS Exceptional Needs Unit:  Metropolitan Referral Unit: | | | | | | | | | |
| Eligibility Check (Please complete all information to ensure the request can be processed quickly). | | | | | | | | | |
| Lives in Metropolitan Adelaide  18 - 65 years (< 50 ATSI)  Client is not eligible to receive equipment through an alternate funding source:  Client has an identified chronic disease/s:  Specify all relevant diagnoses: | | | | | | | | | |
| **Functional Impact** | | | | | | | | | |
| Outline how the client’s chronic condition is impacting their function: | | | | | | | | | |
| **General Program Eligibility** | | | | | | | | | |
| Item requested is disability specific and identified on the EP in-scope [equipment](https://equipmentprogram.sa.gov.au/lists/?a=42265) or [home modifications](https://equipmentprogram.sa.gov.au/__data/assets/excel_doc/0004/20947/Home-mods-in-scope-Reference-Sheet.xls) list.  Item is being requested for use within the client’s primary residence.  Frequency of use will be at least 3-4 times/week | | | | | | | | | |
| [**Key Approval Criteria**](https://equipmentprogram.sa.gov.au/equipment-program/DACCM/eligibility/key-approval-criteria-for-equipment) | | | | | | | | | |
| Item is required to enable the client to remain living at home by supporting one or more of the following  (note all relevant criteria and provide details):  Safety:  Independence / function:  Need for services:  Potential for functional gain:  Prevention of deterioration:  Risk of hospitalisation / residential care:  Need for timely discharge (eligible clients only): | | | | | | | | | |
| **Palliative Condition** | | | | | | | | | |
| Client’s condition is considered palliative:  Y  N  If a palliative condition has been identified:  Has the client been referred to a SA Health – Community Palliative Team:  Y  N  I am the client’s Treating Medical Officer and have consulted with a Palliative Care Specialist (insert details below), who has confirmed the applicant’s condition has a likely prognosis of 12 months or less.  OR  I am the client’s Palliative Care Specialist and confirm that the applicant’s condition has a likely prognosis of 12 months or less. | | | | | | | | | |
| **Consulting Palliative Care Specialist (PCS)**  Not required if PCS has completed the form as the treating Medical Officer  **\*Palliative Care Specialist Definition:** A Doctor who is an AHPRA designated Palliative Medicine Specialist/Physician. | | | | | | | | | |
| AKPS: | | | Phase: | | | | | RUG-ADL: | |
| Prognosis:  1-4 months | | 4-6 months | | | 6-12 months | | | | > 12 months \*not eligible for program\* |
| PSC Name | | | | | Phone | | | | |
| Organisation | | | | | | | | | |
| **NDIS Eligibility** | | | | | | | | | |
| Unable to assess:  NDIS eligibility to be explored:  NDIS application in progress. Application date/progress of application:  Not eligible. Provide evidence of NDIS declined status:  NDIS registered and is receiving support. Further information:  Provide evidence that Assistive Technology has been requested and declined by the NDIS. | | | | | | | | | |
| **Allied Health Service** | | | | | | | | | |
| Is the client currently in hospital / hospice? N  Y If yes, planned discharge date:  **Allied Health Assessment is required through the DHS Equipment Program**  No Specify who will be completing the Allied Health review:  Yes Complete the following: | | | | | | | | | |
| Discipline requested:  OT  PT (note PT must be requested for Mobility Ax / Mobility Equipment)  Functional issues or concerns requiring assessment: | | | | | | | | | |
| **Consent** | | | | | | | | | |
| Client gives consent for the collection and use of their personal information to receive a service including equipment, home modifications or Allied Health Service through the DHS Equipment Program and relevant contractors under the Adults with Chronic Conditions funding stream?   Y  N | | | | | | | | | |
| Submit to [DHSEquipmentProgram@sa.gov.au](mailto:DHSEquipmentProgram@sa.gov.au) or Fax **1300 295 839**  If you have any queries, contact the Equipment Program on **1300 130 302** | | | | | | | | | |