## Adults with Chronic Conditions Registration Form

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

|  |  |
| --- | --- |
| 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 or Fax **1300 295 839** If you have any queries, contact the Equipment Program on **1300 130 302** |