Criteria Screening Tool - Ceiling Hoist

See procedure ‘Completing eligibility assessment screening tool’ for instructions on completing this screen

**Client name:** **Client/file number:**

**Client DOB:** **Client address:**

**Screen Completed by: Name:**

 **Position:**

**Screen Completed with:** ❑ **Client** ❑ **Other:**

 *(Name and relationship to client)*

**Confirm diagnosis/relevant recent medical history:**

**Current Equipment Program equipment:**

**Current services received:**

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| --- |
| **1. Does the client live in a residential aged care facility or receive an Aged Care Package?** ❑ Yes, refer to procedure❑ No, continue with screen |
| **2. Is the client a DVA Gold Card Holder or are they eligible for the equipment item through compensation payment or any other source?** ❑ Yes, if the client is eligible for the item from DVA, compensation or other funding, screening assessment can be stopped at this point, client is ineligible via the Equipment Program. ❑ No, continue with screen |
| **3. Does the client currently have any type of hoist?** *Check current equipment listed* Details of type and ownership: If the client has a ceiling hoist provided by the Equipment Program, record details of issues with it/reasons replacement needed and stop assessment at this point. They are likely to be eligible. |
| **4. How often does/would the client use a ceiling hoist if they had one?** Details:  If hoist is **not** to be used for all transfers, stop screening assessment at this point. Client will be ineligible. |
| **5. How does the client currently transfer? Does anyone help them? Are there any safety concerns for the client or carers?** Details: |
| **6. Has the client tried a mobile hoist? Could they use a mobile hoist instead of a ceiling hoist?** *Consider space available in home for safe use of a hoist, safety issues for carer(s) due to client size, carer’s ability to operate a mobile hoist.* Details of trial or barriers to trial: |
| **7. Could the client complete transfers independently if they had a ceiling hoist?** *Consider information already provided. If yes, discuss how this would occur.* Details:  |
| **8. Are there any other reasons that you believe that the client needs a ceiling hoist that has not already been discussed? Any other information you want to provide?** |
| **9. Does the client give consent for the Equipment Program Delegate to talk to any other health professionals to provide any extra information if needed?** ❑ Yes Details:  ❑ No |

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| --- | --- | --- |
| 1 | Assisted transfers: severely compromised without a ceiling hoist? | Y / N |
| 2 | Independent transfers: would be possible with provision of a ceiling hoist and are severely compromised without it? | Y / N |
| 3 | A mobile hoist has been tried and there is insufficient space to use a mobile hoist in the home? | Y / N |
| 4 | A mobile hoist has been tried and the carer unable to safely use a mobile hoist but could use a ceiling hoist? | Y / N |
| 5 | The ceiling hoist will be used for all transfers? | Y / N |

A **Yes** to any of 1 - 4 **and** 5 is **likely** to make the client eligible for a ceiling hoist.

Signature of person completing the screening assessment

Print Name: Date completed

**To be completed by the Equipment Program Delegate:**

**Final outcome – Eligible? ❑ Yes ❑ No**

Signed by delegate: Date:

Delegate name: Delegate Position:

**❑ Outcome letter sent to client if not eligible**

Signed: Date: