Criteria Screening Tool - Electric Bed

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 person is eligible for the item from DVA, compensation or other funding, screening assessment can be stopped at this point, person is ineligible via Equipment Program. [ ]  No |
| **3. Does the client already have an electric bed?** Details of current bed and ownership (e.g. *Is the current bed funded by the Equipment Program?):*If client has a current electric bed provided by Equipment Program, document issues with it and need for replacement. Person likely to be eligible.  |
| **4. Is the client applying for an Electric Bed to use in their primary residence every night?**If use **less** than daily, check key eligibility criteria as screen may need to be stopped at this point if client is not eligible.  |
| **5. How does the client get in and out of bed?** E.g. slide transfer, standing pivot, from wheelchair, to shower chair etc*. Consider whether bed height is crucial in the type of transfer.* **Does anyone help the client transfer?** *Consider carer’s health and ability to assist.*  |
| **6. Are there any safety issues with how the client transfers in and out of bed for the client or their carer?** *If a carer is ssisting, consider their health and ability to assist.*Details of difficulty: |
| **7. Is the bed used for personal care activities such as dressing or hygiene?** Consid*er how often carer help is required* |
| **8. What other things has the client tried to help them get in and out of bed?** E.g. bed risers |
| **9. Can the client move themselves once they are in bed?** Do they need help with positioning?Details of difficulty: |
| **10. How long does the client spend in bed each day/night?** |
| **11. What other things has the client tried to help them with moving in bed?** E.g. bedstick, bed ladder, overhead self-help poleDetails: |
| **12. Are there any other reasons that the client requires an electric bed that have not been raised? Is there any additional information you want to provide?** *Consider pain which is unable to be relived in another way.* |
| **13. Does the client/carer give consent for the Equipment Program Delegate to talk to other health professionals to provide extra information if needed?** [ ]  Yes Details:  [ ]  No |

|  |  |  |
| --- | --- | --- |
| 1 | Bed mobility: difficulty with independent repositioning and carer at risk or unavailable? | [ ]  Y / [ ]  N |
| 2 | Transfers: adjustment of bed height needed for client or carer safety during transfers? | Y[ ]  / [ ]  N |
| 3 | Height adjustment needed for multiple carers or transfer surfaces? | [ ]  Y / [ ]  N |
| 4 | Pain management issues and client unable to reposition to relieve pain and carer unable or unavailable to assist? | [ ]  Y / [ ]  N |
| 5 | Is client spending prolonged periods in bed? | [ ]  Y / [ ]  N |
| 6 | Bed required for medical purposes? e.g. postural drainage, contractures | [ ]  Y / [ ]  N |
| 7 | Other options have been tried and an electrically operated bed is the most cost-effective option to DHS | [ ]  Y / [ ]  N |

A **yes** to any of 1 – 6 **and** 7 is **likely** to make the client eligible for an electric operated bed.

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

**Eligible?** [ ]  **Yes** [ ]  **No**

Signature of person reviewing the screening assessment

Print Name and Position:

Date completed:

[ ]  **Outcome letter sent to client if not eligible**

Signed: Date: