# Advanced Palliative Equipment Response (APER) 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  Non-binary  Prefer to not answer  Different term | | | | | |
| Email | | | Client Weight | | |
| Residential Address | | | | | |
| Suburb | | | Postcode | | |
| Postal Address (if different from above) | | | | | |
| 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 | | | Profession | | |
| Organisation | | | | | |
| Email | | | Phone | | |
| Signature | | | Date | | |
| Eligibility Criteria | | | | | |
| Lives in Metropolitan Adelaide  Is registered and an active client of a community palliative service (SA Health Specialist Palliative Service). Please specify:  CAPCS  NAPS  SAPS  WCH  Palliative Consult Liaison Nurse (Name):  has confirmed registration pending with  CAPCS  NAPS  SAPS  Is in the end stages of their illness as agreed by the palliative service (expected to require services for less than 16 weeks)  Requires a rapid service response due to the deteriorating nature of their condition. | | | | | |

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| **Alternate Funding Sources** | | |
| Client is currently in receipt of service/equipment funding?  N  Y  Please check all that apply:  MRU  ACC  NDIS  CHSP  Other (specify)  HCP Level 1/2 - provider name/contact number:  HCP Level 3/4 - provider name/contact number:  I have contacted the above provider to discuss funding of equipment  N  Y  N/A  Please provide details of outcome:  I confirm the client is unable to access equipment through alternate funding source in a timely manner. | | |
| **Medical History** | | |
| Relevant Diagnosis:  Additional Information:  AKPS: | Phase: | RUG-ADL: |
| Prognosis:  1-2 weeks  < 1 month  1-4 months  4-6 months  > 6 months | | |
| **Consent** | | |
| Client gives consent for the Equipment Program to liaise with and provide relevant personal details to other service providers as required?  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** | | |