# Advanced Palliative Equipment Response (APER) 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 [ ]  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.  |

|  |
| --- |
| **Alternate Funding Sources** |
| Client is currently in receipt of service/equipment funding? **[ ]**  N **[ ]**  YPlease 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/APlease 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 or Fax **1300 295 839** If you have any queries, contact the Equipment Program on **1300 130 302** |