# Medical Grade Footwear and Lower Limb Orthoses Request Form

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| Client Details |  |
| Phone        | Date of Birth        |
| Last Name       | First Name       |
| Preferred Name       | Gender [ ]  M [ ]  F [ ]  Non-binary  |
| Email        |
| Usual Address        |
| Suburb       | Postcode       |
| Interpreter required [ ]  Y - Primary Language       [ ]  N |
| Indigenous Status [ ]  Aboriginal [ ]  TSI [ ]  Aboriginal and TSI [ ]  Neither [ ]  Not stated |
| Alternate contact (if applicable) [ ]  Guardian [ ]  Other Preferred contact [ ]  Y [ ]  N |
| Name       | Relationship       |
| Phone       | Email        |
| Communication Instructions:       |  |
| Alternate Funding Options (Client meets the following criteria):[ ]  Client is not registered with the NDIS[ ]  Client is not registered with My Aged Care[ ]  Client is registered with My Aged Care - [ ]  CHSP [ ]  HCP L1 [ ]  HCP L2 [ ]  HCP L3 [ ]  HCP L4Funding is not available through MAC (provide reason):       [ ]  Client does not have Private Health Insurance available to cover item |
| Client’s Relevant Diagnosis:       |
| Client’s Relevant Medical History:       |

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| Foot / Ankle Orthoses Required [ ]  No [ ]  Yes (please complete section below) |
| Meets the following criteria (at least one criterion must be met for new or replacement orthoses): [ ]  Safety: Orthoses will minimise the risk of serious injury to the client. Details:      [ ]  Independence/function: Without Orthoses the client is compromised when completing daily living tasks.Details:      [ ]  Prevention of deterioration: Orthoses will reduce progression of functional and or postural deterioration.Details:      [ ]  Potential for functional gain: Orthoses will facilitate the client to make improvements in their functional capacity.Details:       |
| Is this a replacement item or a new need? **[ ]**  Replacement **[ ]**  New need |
| Identify how this item will meet the Specific Eligibility Criteria for Orthoses:       |
| Type of orthoses being requested |
| [ ]  Left [ ]  Right [ ]  Bilateral |
| [ ]  Foot [ ]  Ankle/Foot [ ]  Knee AFO [ ]  Hip Knee AFO |
| [ ]  Prefabricated | Off the shelf Orthoses that are fitted to the foot and shoe (length, width and depth may be adjusted) |
| [ ]  Customised | Prefabricated Foot Orthoses and Ankle Foot Orthoses that are adapted to individual requirements (i.e. customised)  |
| [ ]  Custom Made | Foot Orthoses and Ankle Foot Orthoses that are custom made to the needs and measurements of the person |
| Outline reason for selection made       |
| Outline any safety precaution alerts       |
| Supplier Name:       Contact number:       | Email:       |

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| **Medical Grade Footwear (MGF) required** [ ]  No [ ]  Yes (please complete section below) |
| Meets the following criteria (at least one must be met for new or replacement MGF):[ ]  Safety: MGF will minimise the risk of serious injury to the client.Details:      [ ]  Independence/function: Without MGF the client is compromised when completing daily living tasks.Details:      [ ]  Prevention of deterioration: MGF will reduce progression of functional and or postural deterioration.Details:      [ ]  Potential for functional gain: MGF will facilitate the client to make improvements in their functional capacity.Details:       |
| Is this a replacement item or a new need? **[ ]**  Replacement **[ ]**  New need |
| Identify how this item will meet the Specific Eligibility Criteria for MGF:       |
| **Type of MGF being requested** |
| [ ]  Left [ ]  Right [ ]  Bilateral |
| [ ]  Extra wide[ ]  Extra depth [ ]  Rocker sole | [ ]  Lace up[ ]  Velcro[ ]  Buckle | [ ]  To accommodate orthomechanical device[ ]  To accommodate insole etc.[ ]  Heel/sole lift[ ]  Other:       |
| [ ]  Prefabricated | ‘Off-the-shelf’ footwear with specialised features such as extra depth/width. |
| [ ]  Customised | Prefabricated MGF adapted to individual requirements i.e. “customised”. |
| [ ]  Custom Made | Designed and manufactured for a specific person who requires an individual mould and a distinct set of specifications, patterns and casts established for each foot.Has Prefabricated or Customised MGF been trialed in the past? [ ]  Yes [ ]  No [ ]  Not suitable       |
| Outline reason for selection made       |
| Outline any safety precaution alerts       |
| Supplier Name:       Contact number:       | Email:       |
| Assessor Details |
| Name        | Discipline       | AHPRA #       |
| Organisation and Team Name       | Phone        | Email       |
| [ ]  I have assessed the client and believe the items will meet the client’s needs.[ ]  I agree to complete follow up fitting with client to assure suitability[ ]  I have attached the Risk Rating & Priority Score form[ ]  I have attached a quote for the requested item  |
| Signature       | Date        |
| Submit to: DHSEquipmentProgram@sa.gov.au or Fax to 1300 295 839 |

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| Equipment Program delegate - Internal Use Only |
| CSO       | Signed       | Date       |
| Delegate       | Signed       | Date       |