# 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 L4  Funding 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](mailto: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 |