**Wig Request Form**

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| Client Details | | | (Internal Use only) ESIS ID: | |
| Phone | | | Date of Birth | |
| Last name | | | First Name | |
| Preferred Name | | | Gender  M  F  Non-binary | |
| Email | | | | |
| Usual Address       Suburb       Postcode | | | | |
| Interpreter required  N  Y - Primary Language: | | | | |
| **Alternate Contact** (if applicable)  Guardian  Other Preferred contact  Y  N | | | | |
| Name | Relationship       Phone | | | |
| Medical Practitioner Details | | | | |
| Name | | Provider Number | | |
| Clinic Name | | | | |
| Email | | Phone | | |
| **Complete the following**  Client has a permanent loss of hair as a result of a major illness or treatment of a major illness.  Diagnois relevant to hair loss: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if alopecia please specify type)  How long has the client had this diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Percentage of permanent scalp hair loss: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How long has the client experienced the above degree of scalp hair loss: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  It is at least 12 months since the issue of a wig from an acute care service provider (eg hospital).  Not applicable  No alternate funding sources are available. | | | | |
| **Medical Practioner Signature** | | | | Date |
| Request Details | | | | |
| **Type of wig requested**  Acrylic wig (must be at least 12-month since last provision of wig through EP)  Human hair wig (must be at least 5 years since last provision of wig through EP) | | | | |
| I have conducted my own research in chosing the above type of wig and understand my responsibility for  maintaining the chosen wig if it is supplied under the Equipment Program (EP)  I have a preferred wig supplier (provide name and number)  I do not have a preferred supplier (Equipment Program will contact you to discuss supplier options**)** | | | | |
| Client / Guardian Signature | | | | Date |
| Submit to | | | | |
| Email request form to [DHSEquipmentProgram@sa.gov.au](mailto:DHSEquipmentProgram@sa.gov.au) or fax to 1300 295 839  You will be contacted with the outcome of this request. If approved you will be asked to get a quote. | | | | |
| Internal Use Only | | | |  |
| Wig/s previously supplied by Equipment Program (List date of most recent wig provided)  Not applicable  Date:        Acrylic wig  Human hair wig  Authorised by: Name       Signed       Date | | | | |

The information is confidential and may be subject to legal professional privilege or public interest immunity. If you have received in error, any use, disclosure or copying of this document and/or attachments is unauthorised.

Equipment Program – Wig Request Form | Last Updated 3 December 2020

Phone: 1300 130 302 | Email: [DHSEquipmentProgram@sa.gov.au](mailto:DHSEquipmentProgram@sa.gov.au) | Web: [www.equipmentprogram.sa.gov.au](http://www.equipmentprogram.sa.gov.au)