|  |  |
| --- | --- |
| Client Details | Client ID (DSOA / SA Health / Other):        |
| Funding Stream [ ]  APER [ ]  ACC [ ]  DSOA [ ]  Custom Mobility [ ]  Legacy  |
| Phone        | Date of Birth        |
| Prefix       | Last Name       | First Name       |
| Preferred Name        | Pronouns:        |
| Gender: [ ]  M [ ]  F [ ]  Non-binary [ ]  Prefer to not answer [ ]  Different term        |
| Email        |
| Residential Address        |
| Suburb       Postcode       |
| Interpreter required [ ]  Y Primary Language       [ ]  N |
| Indigenous Status: [ ]  Aboriginal [ ]  TSI [ ]  Aboriginal and TSI [ ]  neither [ ]  not stated |
| Weight (KG) [ ]  <40 [ ]  >40 [ ]  >90 [ ]  >110 [ ]  >120 [ ]  >150 [ ]  >170 [ ]  >190 [ ]  >210 |
| Alternate contact (if applicable) [ ]  Guardian [ ]  Other Preferred contact [ ]  Y [ ]  N |
| Name       | Relationship       |
| Phone        | Email       |
| Equipment Request Details |
| Delivery Instructions: [ ]  Contact assessor before delivery Address (if not as above):      Special needs / contact person / number / installation heights / location, etc:        |
| Safety Instructions (Precautions / ALERTS for contractor staff to see) [ ]  Nil Alerts [ ]  Alerts (provide details)       |
| **Home Access** (for large items e.g. beds, recliners, air chairs, hoist/lifters): Access through [ ]  Front [ ]  Back [ ]  Other:       Steps: [ ]  N [ ]  Y If steps/stairs/steep driveway, please provide detail:       Internal Layout: Any issues for larger items (ERC/Air chair) e.g. Tight turns, obstacles, narrow passage width. Please provide detail:        |
| Is client in hospital / hospice / respite [ ]  Y [ ]  N  | Planned discharge date       |
| Delivery Timeframe: [ ]  Standard [ ]  Urgent Preferred Delivery Time: **[ ]**  AM **[ ]**  PM **[ ]**  Any |
| Item Code(If available) | Equipment Description | Asset number:(If known) | Qty | Is this a replace-ment item? | Can a substitute be offered? | CAT1 or 2 | Priority 1-12(Cat 2 items only) |
|       |       |       |  |  |  |  |  |
|       |       |       |  |  |  |  |  |
|       |       |       |  |  |  |  |  |
|       |       |       |  |  |  |  |  |
|       |       |       |  |  |  |  |  |
| Assessment and Assessor Details |
| Name        | Phone (and pager if applicable)      |
| Discipline:       Organisation:       Email       |
| [ ]  I have assessed the client and believe items will meet the client’s needs[ ]  I have the clinical knowledge and expertise to prescribe the requested equipment items |
| Assessment report(s) / attached [ ]  Y [ ]  NI agree to complete a post-delivery follow up (phone or visit): [ ]  Y [ ]  N**APER/ACC only**: Is OT/PT follow up required by the Equipment Program [ ]  Y [ ]  NIf yes, indicate: [ ]  OT [ ]  PT [ ]  BothPlease provide details of the assessment required via email or complete the Allied Health Assessment Request Form  |
| Signature       | Date        |
| Submit for Approval: DHSEquipmentProgram@sa.gov.au  |
| Internal Use Only [ ]  APER [ ]  ACC [ ]  DSOA [ ]  Custom Mobility [ ]  Legacy |
| CSO | **Name**       | **Signed**       | **Date**       |
| Delegate | **Name**       | **Signed**       | **Date**       |