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| 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? | | CAT  1 or 2 | Priority 1-12  (Cat 2 items only) |
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| 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  N  I 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  N  If yes, indicate:  OT  PT  Both  Please 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](mailto:DHSEquipmentProgram@sa.gov.au) | | | | | | | | | | | | | | | | | |
| Internal Use Only  APER  ACC  DSOA  Custom Mobility  Legacy | | | | | | | | | | | | | | | | | |
| CSO | **Name** | | | | | | | **Signed** | | | | | | | **Date** | | |
| Delegate | **Name** | | | | | | | **Signed** | | | | | | | **Date** | | |