|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please indicate program** CHSP  TCP  RIHHT  Other | | | | | | | | | | | |
| **Client Details** | | **(DES Internal Use only) ESIS ID:** | | | | | **CME Client No.** | | | | |
| Phone       Date of Birth | | | | | | | | | | | |
| Prefix  Last Name       First Name | | | | | | | | | | | |
| Preferred Name       Gender  M  F  Non-binary | | | | | | | | | | | |
| Email | | | | | | | | | | | |
| Usual Address | | | | | | | | | | | |
| Suburb | | | | | | Postcode | | | | | |
| Interpreter required  Y Primary Language:        N | | | | | | | | | | | |
| Weight (KG) <90 >90 >110 >120 >130 >150 >170 >190 >210 | | | | | | | | | | | |
| **Alternate Contact** (if applicable)  Guardian  Other Preferred Contact?  Y  N | | | | | | | | | | | |
| Name | | | | | | Relationship | | | | | |
| Phone | | | Email | | | | | | | | |
| Equipment Request Details | | | | | | | | | | | |
| Delivery (Address if not as above/contact person/phone/special needs)  Contact assessor before delivery | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Safety instructions** (Precautions/alerts for DES delivery staff only to see)  Nil Alerts  Alerts (provide details) | | | | | | | | | | | |
| Time:  AM PM Any Priority:  Standard  Urgent (additional cost applies)  (Exact hour not available) | | | | | | | | Quantity | | Is this a replacement item | Can a substitute item be offered |
| DES Item code  (if available) | EQUIPMENT DESCRIPTION | | | | | | |
|  |  | | | | | | |  | |  |  |
|  |  | | | | | | |  | |  |  |
|  |  | | | | | | |  | |  |  |
|  |  | | | | | | |  | |  |  |
|  |  | | | | | | |  | |  |  |
|  |  | | | | | | |  | |  |  |
| Assessor Details & Checklist | | | | | | | | | | | |
| Name | | | | | Profession | | | | Date | | |
| Team | | | | Email | | | | | | | |
| Phone | | | |  | | | | | | | |
| I have assessed the client and believe the items will meet their needs  I agree to complete follow up contact with the client once the equipment is delivered to assure suitability | | | | | | | | | | | |
| Submit for Approval / Supply | | | | | | | | | | | |
| I am an RDNS clinician – Submit to DES [des.frontdesk@sa.gov.au](mailto:des.frontdesk@sa.gov.au)  I am NOT an RDNS staff member – submit to RDNS SA/Domiciliary Care Services - **Fax number 1300 295 679** | | | | | | | | | | | |
| RDNS Internal Use Only | | | | | | | | | | | |
| External request check complete Processed by       Date | | | | | | | | | | | |