**Equipment Request Form – State Funding**

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| Client Details | Client ID (DSOA / SA Health / Other): | |
| Funding Stream  APER  ACC  DSOA  Custom Mobility  Legacy | | |
| Family Name: | | First Name: |
| Preferred Name: | | Pronouns: |
| Gender:  M  F  Non-binary  Prefer to not answer  Different term | | |
| Date of Birth: | | Height (cm): |
| Weight (KG):  <40  >40  >90  >110  >120  Over 150kg (specify): | | |
| Email: | | Phone: |
| Residential Address: | | |
| Suburb: | | Postcode: |
| Interpreter required:  Yes:        No | | |
| Alternate contact (if applicable)  Guardian  Other Preferred contact  Y  N | | |
| Name: | | Relationship: |
| Phone: | | Email: |
| Equipment Request Details | | |
| Safety Instructions (Precautions / ALERTS for contractor staff to see)  Nil Alerts  Alerts (provide details): | | |
| Delivery Instructions:  Contact assessor before delivery  Address (if not as above):  Details of installation heights / special needs / additional contact person and number / location in home: | | |

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| **Home Access**:  Access through  Front  Back  Other:       Steps:  N  Y  External Issues: Access challenges e.g. number of steps / dirt pathway / steep driveway.  Please provide detail:  Internal Issues: Internal steps/stairs, tight turns, obstacles, narrow passage width.  Please provide detail: | | | | | | | |
| Is client in hospital / hospice / respite:  Y  N | | | Planned discharge date: | | | | |
| Delivery Timeframe:  Urgent  Standard – preferred delivery date:  Preferred Delivery Time:  AM  PM  Any | | | | | | | |
| Item Code  (If available) | Equipment Description | Asset number:  (If known) | Qty | Is this a replacement 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 the 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 *or* complete the Allied Health Assessment Request Form: | | | | | |
| Signature: | | | | | Date: |
| Submit to [DHSEquipmentProgram@sa.gov.au](mailto:DHSEquipmentProgram@sa.gov.au) or Fax **1300 295 839**  If you have any queries, contact the Equipment Program on 1300 130 302 | | | | | |
| Internal Use Only:  APER  ACC  DSOA  Custom Mobility  Legacy | | | | | |
| CSO | **Name:** | | **Signed:** | **Date:** | |
| Delegate | **Name:** | | **Signed:** | **Date:** | |