**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? | CAT1 or 2 | Priority1-12(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 [ ]  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 *or* complete the Allied Health Assessment Request Form:         |
| Signature:       | Date:        |
| Submit to 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:**       |