

EQUIPMENT PRESCRIPTION FORM



The information in this form is for use by the organisation which has requested it and will not otherwise be exchanged with any other party, except in accordance with law. Please see section 15 of this form for privacy information.

IMPORTANT

- Please type or use block letters and **ensure that all sections are complete**. All incomplete forms will be returned, so please give reasons if you are unable to complete a section
- Where there is insufficient space, please attach further information to the back of this form.

This form must be completed for all requests for the following equipment

▪ Wheelchairs	▪ Recumbent trikes	▪ Large exercise equipment
▪ Pressure cushions	▪ Beds	▪ Lounge chairs / tilt recliners
▪ Powered conversion kits	▪ Mattresses	▪ Custom toilet / shower / commode chairs
▪ Hoists	▪ Standing frames	▪ Shower trolleys
▪ Scooters	▪ Tilt tables	▪ Mainstream multifunctional technology (i.e. tablets, smartphones, computers. etc.)
▪ Bikes	▪ Treatment couches	▪ Ramps
▪ Any other specialised or customised equipment item		

This form must also be completed for modifications to existing equipment in the above list.

Where appropriate please contact the TAC Equipment Contractors to conduct trials of equipment.

TAC Equipment Contractors are:

Country Care Group

Phone 1800 843 224

Email contracts@countrycaregroup.com.au

www.countrycaregroup.com.au

Aidacare

Phone 9981 2100

Email tac@aidacare.com.au

www.aidacare.com.au

Independence Australia (Mobility Aids Australia)

Phone 1800 625 530

Email tac@mobilityaids.com.au

www.independenceaustralia.com.au

www.mobilityaids.com.au

1. Your details

SWEP Red level Occupational Therapist	All other providers
<input type="checkbox"/> SWEP Red level Occupational Therapist NOTE: You must only complete Section 12 if you are requesting follow-up services	<input type="checkbox"/> Occupational Therapist without SWEP Red level credentials NOTE: You do not need to complete Section 12 <input type="checkbox"/> Other health professional, e.g. physiotherapist NOTE: You do not need to complete Section 12

EQUIPMENT PRESCRIPTION FORM

2. Client details

Client name

Client address

Postcode

Claim number

Telephone number

Date of Birth

Date of injury

Date of assessment

Date report submitted

Delivery contact person

Delivery contact telephone number

Delivery address and instructions

3. Current level of function

Transport accident injuries and relevant medical history. *Consider cognitive function/behaviour and prognosis*

Social situation. *Consider where the client lives, who he/she lives with, any other formal or informal supports, and if there are any plans for change in the future*

Specific functional limitations. *Consider height, weight, upper and lower limb function, posture, balance, cognitive, communication, behavioural or emotional issues resulting from the transport accident injury*

Current functional status. *Include a general overview of the client level of function in the following areas: transfers, mobility, pressure management, personal care, domestic tasks, community access and work/recreation/leisure. Include details specifically relevant to the equipment being prescribed*

EQUIPMENT PRESCRIPTION FORM

4. Clinical justification

Purpose of recommended equipment. *Consider intended ADLs, social and intended use (indoors, outdoors and frequency)*

Expected measurable outcomes. *Please be specific about how the equipment will maximise functional independence and/or support clinical goals*

5. Discussion with treating healthcare professionals

Provide the outcomes of the discussions you have had with the client's other treating healthcare professionals about your recommendations. *Include any differences in opinion or support for your recommendations*

6. Trials

Did you make your recommendation after trialling products from the *TAC Equipment Contractors*? Yes No

If 'no', please provide clinical reasoning to support why the *TAC Equipment Contractors* products did not meet the client needs

Please note that the trialling of products from the *TAC Equipment Contractors* is mandatory. Failure to do so without clinical justification will result in the *Equipment Prescription Form* being returned.

Details of the trial

Equipment. Include all equipment trialled, including the equipment you recommend in section 7	Length and location of trial. Include equipment provider name	Outcomes and client/carer feedback. Include justification for the equipment you recommend in section 7

EQUIPMENT PRESCRIPTION FORM

7. Details of recommended equipment

Details of recommended equipment, including model and specifications

Are non-standard options or non-standard customisations required? Yes No

If 'yes', please specify feature, function and clinical justification for non-standard options and customisations

Have you considered day-to-day transportation of the equipment? Yes No Not applicable

Have you considered the compatibility with existing equipment and the client's environment? Yes No

Have you considered the safety of the client and carers with this equipment? Yes No

Has there been multidisciplinary team consensus? Yes No

Is this equipment available from the Equipment Contractors? * Yes No

*If 'no', the Claims Manager will refer the order to the Equipment Brokerage Team

Additional comments. *Please provide more information where the answer to any of the above is 'no'*

Method of equipment provision

Purchase

Hire

If hire, for how long?

* Please consider purchase of equipment if hire is for an extended period of time and the hire cost will exceed the cost to purchase the item.

Type of supply

Initial provision

Replacement

Modification

If equipment is being replaced or modified, please specify the following

Type and model of current equipment

Date purchased

/ /

EQUIPMENT PRESCRIPTION FORM

Limitation of current equipment

Reasons for replacement

8. Quotation

Only required for customised items and items that do not appear on the Equipment List

Has the selected Equipment Contractor provided a written quotation? Yes No

If 'no', explain why the equipment is not available through the Equipment Contractors

9. Anticipated maintenance

Consider warranty and supplier's recommended service schedule. For example, requires annual mechanical servicing, etc.

10. Are there any training requirements?

Yes No

If 'yes', outline anticipated training requirements for the client and/or carers

11. Will you conduct a review of the equipment after delivery?

Yes No

If 'no', please explain why a review is not required

EQUIPMENT PRESCRIPTION FORM

12. SWEP Red level Occupational Therapist only

Prescribing occupational therapist follow-up services

The TAC is able to approve a maximum of 6 hours to provide follow-up services.

Explain why follow-up services or training are recommended	Frequency and duration of follow-up services, e.g. <i>Weekly follow-up for 2 months</i>	Comments, including additional travel time

Is a referral for further occupational therapy services required?

Yes No

Referral is required if follow-up is anticipated to be greater than 6 hours. If 'yes', please outline the areas that need to be addressed

13. Additional comments

14. Prescribing Occupational Therapist or health professional details

I have discussed the information contained in the *Equipment Prescription Form* with the client or carers and other members of the treating team, including the requested equipment, the aims, predicted outcomes, maintenance and training requirements.

Provider name, address and phone no. *Use practice stamp where possible*

Signature

Days/hours available

Date

/ /

15. Personal and health information

TAC

The TAC will retain the information provided and may use or disclose it to make further inquiries or assist in the ongoing management of the claim or any claim for common law damages. The TAC may also be required by law to disclose this information. Without this information the TAC may be unable to determine entitlements or assess whether treatment is reasonable and may not be able to approve further benefits and treatment