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| Please complete all Sections | | | | | | | | | | | | | |
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| **1. Client Details** | | | | | | | | | | | | | |
| Client ID: | | |  | | | Is the applicant an existing TEP client? | | | | | Yes | No | Unsure |
| CRN  (Pension No.):  \*TEP Clients only | | | |  | | *A TEP Application Form is required for all new applicants, and existing clients whose situation has changed or requires confirmation (Special Consideration)* | | | | | | | |
| Surname: | |  | | | | | Given Names: | | |  | | | |
| Preferred Phone: | | | | |  | | Mobile: |  | | | | | |
| Email: |  | | | | | | Date of Birth: | | /    / | | | | |
| Residential Address: | | | | | |  | | | | | | | |
| Postal Address (if different): | | | | | |  | | | | | | | |
| Parent/Guardian (if applicable): | | | | | |  | | | | | | | |
| Contact Details (if different): | | | | | |  | | | | | | | |

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| **2. Identification of Need/Clinical Criteria** |
| Client Diagnosis and Details of Functional impairment: |
| Please ‘check’ as relevant **for each** criteria – Clinical, Functional and Social:  **Clinical Criteria**  The client must meet at least **ONE** of the following clinical criteria prior to the approval of a PERS:  Has a significant risk of a medical emergency. The client should have a medical condition that requires immediate and urgent response and be unlikely to be able to obtain assistance through conventional means e.g. poorly controlled diabetes or epilepsy; **AND/OR**  Has a recent history (within the past 12 months) of falls. The falls should have been investigated and the cause of the falls eliminated where possible. Therefore personal response systems should only be considered if there is a continued risk of falls; **AND**/**OR**  Displays a number of factors that would put them at high risk of a fall. Risk factors include severe visual impairment, severe mobility and balance problems, severe incontinence, and medical conditions which affect balance and mobility (such as Parkinson’s disease or Meniere’s disease).  **Functional Criteria**  The client should meet **ALL**the functional criterialisted below prior to the approval of a PERS:  Has sufficient physical function to operate the alarm; **AND**  Has sufficient cognitive function to wear and to operate the alarm; **AND**  Is willing to wear the alarm device 24 hours a day; **AND**  Is willing to activate the system if necessary  **Social Criteria**  The client must meet at least **ONE**of the following social criteria prior to the approval of a Monitored Alarm System:  Lives alone; **OR**  Does not live alone but is without assistance for a significant proportion of the day or night; **OR**  Does not live alone, but their carer is unable to provide or obtain assistance (eg. due to significant hearing impairment, dementia or mobility problems); **OR**  Provision of an alarm could prevent the need for client to be placed into low-level residential or supported accommodation.  **If applying for a Monitored Alarm System:**  Client has the means and willingness to fund the ongoing system monitoring fees.  Client has the means and willingness to fund the ongoing operating charges for the SIM card |

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| **3. Equipment Decision and Justification** (Please refer to Clinical Guidelines) | | | | | |
| **Client Factors** | | | | | |
| Please provide clinical justification for equipment and its features; | | | | | |
| Is any change anticipated that may impact on the equipment request? | Yes | | No | | N/A |
| If Yes, please comment on how the equipment will accommodate an anticipated change:  *For example, any relevant medical information that impacts on client’s current and ongoing ability to use the equipment/modification such as deterioration or improvement in condition, physiological issues.* | | | | | |
| **Social/Carer Factors** | | | | | |
| What are the implications for the client and/or carer if this equipment is not provided? | | | | | |
| Carer/client is in agreement with client using the equipment? | Yes | No | | | N/A |
| Carer/client understands the purpose and operation of the system and will use it responsibly? | Yes | No | | | N/A |
| Three to five contact persons can be listed on the contacts form? | Yes | No | | | N/A |
| *If No to any of the above please explain*: | | | | | |
| **Environmental and Equipment Factors** | | | | | |
| Does the client have a telephone installed (landline)? | Yes | No | | N/A | |
| Is the client willing to have a telephone installed? | Yes | No | | N/A | |
| Will the client independently meet all telephone/SIM lease and call charges?  *(TEP will not fund telephone provision or any additional telephone requirements prior to the installation of the alarm system)* | Yes | No | | N/A | |
| Does client have more than one phone, an answering machine, fax or dial up modem?  *(If Yes, client may need to install Mode 3 wiring or a Mode 3 Adaptor Plug)* | Yes | No | | N/A | |
| Does client have a nbn™ connection?  *(If so please ensure PERS prescribed is compatible with nbn™)* | Yes | No | | N/A | |
| Power point is available to be used exclusively by the equipment? | Yes | No | | N/A | |
| Power point is 125 mm (5 inches) above the floor or bench, and it is within 1metre of the telephone socket? | Yes | No | | N/A | |
| Does the client have broadband internet connection?  *(If Yes, client may need to install an ADSL Splitter/Filter)* | Yes | No | | N/A | |
| Does the client have a monitored home security system?  *(This may interfere with the signals)* | Yes | No | | N/A | |
| Is the client willing to accept and agree to have the personal alarm system and understands and agrees to the terms and conditions of use? | Yes | No | | N/A | |
| *If No to any of the above, please explain*: | | | | | |
| *Any other relevant considerations:* | | | | | |

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| **4. Trial or Investigation** | | |
| **Trial or Investigation of the equipment may be required.** Refer to TEP Approved Equipment List.  Evaluation of equipment trial/s (T) and/or investigation (I)  Include detailed information regarding all equipment trialled or investigated, including the specific item recommended and/or customisation. This may include client’s current equipment | | |
| **T or I** | **Equipment Trialled/Investigated**  (specific model or specifications) | **Outcome**  (include comparisons of options investigated and/or trialled, include objective measures of goal attainment, length of trial and client’s ability to participate in functional activities with, and without, the equipment) |
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| **5. Equipment Recommendation** | | | | | | | |
| Refer to TEP Approved Equipment List to complete this section. Available stock (new or re-issue) is to be considered prior to recommendation. New items will not be provided where a re‑issue item is available and meets the assessed need of the client.  Include TEP ‘T’/’H’ Number and model/item number if issued from TEP stock, if not in stock please supply a quote. Attach quote/s for non-stock items. | | | | | | | |
| **Item** | **Qty** | **Equipment** | **Item description** (specific model &/or specifications required) | **‘T’/’H’ No.** | **Stock** | **Supplier details & Quote (if applicable)** ($) | **Clinical Priority** |
| 1 |  |  |  | T |  |  |  |
| **Clinical Prioritisation:**  **1** (Essential) **2** (Improve/maintain) **3** (Therapeutic/contributes)  This is an indication of the clinically assessed priority for the prescribed item and should be justified within the prescription details. Refer to Clinical Guidelines. | | | | | | | |
| If prescription is for a **Monitored Alarm System:**  Is the client/guardian aware of the ongoing rental fee for monitored system requirement?  Yes  No  Has client/guardian agreed to pay this ongoing cost?  Yes  No  *TEP will not fund ongoing rental of monitored system* | | | | | | | |

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| **6. Plan for Delivery** | |
| Provide name and contact details of client/carer and any clinicians who must be notified prior to delivery  Prescriber  Client  Other*, please provide contact details:* | |
| Delivery Instructions  TEP to arrange | If equipment is to be delivered to a remote community please provide the following;  Community clinic or Aged Care Centre: Click or tap here to enter text.  Contact person:Click or tap here to enter text.  Phone number: Click or tap here to enter text.  Email address: Click or tap here to enter text. |
| ☐ Prescriber to deliver  ☐ Equipment already delivered – TEP Receipt and Acknowledgement (EI-R) MUST be attached  ☐ Other, give details: | |
| Provide details of who will set up equipment and train client in the use of the equipment (this is a requirement of this prescription): | |
| *Special instructions (eg. dogs, telephone prior to delivery, instructions re equipment for replacement etc):* | |
| Is this prescription for replacement of an existing item?  Yes  No  If Yes, identify a plan to remove/return existing/unsuitable item:  TEP to collect item being replaced or  Prescriber to arrange return of item being replaced  Other*,* *give details:* | |

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| **7. Equipment Review** |
| It is the prescribing therapist’s responsibility to ensure correct fitting and client education for TEP equipment on issue.  In addition, planned review is recommended within 12 weeks of delivery and use. Please indicate mode of review arranged for equipment following issue:  Home visit  Telephone Call  Client to contact prescriber as needed  Other *(state details of referral made for follow up, as required):*  **It is strongly recommended that personal alarms (monitored and non-monitored) are registered with the nbn™ Medical Alarm Register to help identify homes where support may be need to help minimise a break in services. Registration is free, please see nbn.com.au/medicalregister for further details.** |

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| **8. Resources** | | | | |
| Please attach relevant Resources for this prescription. Refer to Clinical Guidelines.  **Required** Resources attached, **one** of the following: | | | | |
| Mini Mental State Examination (MMSE) **OR** |  | Yes |  | No |
| Rowland Universal Dementia Assessment Scale (RUDAS) **OR** |  | Yes |  | No |
| Kimberley Indigenous Cognitive Assessment (KICA-Cog) |  | Yes |  | No |
| **AND** **one** of the following: | | | | |
| Falls Risk for Older People – Community setting (FROP-Com) **OR** |  | Yes |  | No |
| Falls Risk Assessment Tool (FRAT) **OR** |  | Yes |  | No |
| Berg Balance Scale |  | Yes |  | No |
| **AND** | | | | |
| Emergency Contact List |  | Yes |  | No |

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| **9. Prescriber Details** | | | | | | |
| Prescriber Name: | |  | Approved Prescriber No.: | | |  |
| I declare that I am an Approved Prescriber of the appropriate level to prescribe this equipment according to the TEP Clinical Guidelines and TEP Professional Criteria for Approved Prescribers.  **OR**  I declare that I have completed this prescription which has been endorsed by an Approved Prescriber of an appropriate level to prescribe this equipment, according to TEP Clinical Guidelines and TEP Professional Criteria for Approved Prescribers. | | | | | | |
| Signature: | | | Date:    /    / | | | |
| Qualification: |  | | Email: |  | | |
| Work Unit: |  | | Contact Number: | |  | |

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| **10. Endorsement** (As required) | | | | | | | |
| Endorsed by Approved Prescriber Name: | | | |  | | | |
| Approved Prescriber No.: | | |  | | Qualification: |  | |
| Work Unit: | |  | | | Contact Number: | |  |
| Email: |  | | | | | | |
| I endorse this prescription which has been completed by the above Approved Prescriber and acknowledge that all necessary assessments and clinical considerations have been completed and that the prescription is appropriate to the client | | | | | | | |
| Signature: | | | | | Date:    /    / | | |

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| **TEP Clinical Approval** (Office use only) | | |
| Approved Prescriber registration confirmed?  Yes  No *If No, contact prescriber*  AP Number format: TEP Admin Number - Level and Equip Type - Level and Equip Type eg. 52-G1SPMW-G2V | | |
| **Approved** (Pending TEP Cost Centre Manager approval)  All Items / Only Items 1 / 2 / 3 / 4 / 5 / Other:       (please circle) | | **Not Approved** |
| Provide brief rationale: | | |
| Name: | | Title: |
| Signature: | | Date:    /    / |
| Completed forms should be, posted or emailed to: | | |
| **Central Australia** *(includes Alice Springs, Remote Barkly)* E: centralaustraliaintake.THS@nt.gov.au  A: PO Box 721,   Alice Springs NT 0871 | **Top End** *(includes Darwin rural area, Katherine, East Arnhem)*  E: topendintake.THS@nt.gov.au  A: PO Box 40596,  Casuarina NT 0811 | |

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| **Version Number:** | Version: 11.0 | | **Approved Date:** 03/03/2022 | | **Review Date:** 01/02/2024 |