This form may be used to prescribe multiple level 1 items

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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: | | | | |  | | | | | | | | |
| Parent/Guardian (if applicable): | | | | | |  | | | | | | | |
| Contact Details (if different): | | | | | |  | | | | | | | |

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| **2. Equipment Types** |
| **What category of equipment is being requested (please tick all being requested)** |
| Communication Aids and Devices |
| Aids for Daily Living |
| Bed Equipment |
| Pressure Management Equipment |
| Wheeled Mobility Aids |
| Ambulant Mobility Aids |

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| **3. Identification of Need/Clinical Criteria** *(Refer to relevant Clinical Guidelines)* |
| Client Diagnosis and Details of Functional impairment: |
| Please describe why each piece of equipment is clinically indicated: |

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| **4. 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 if issued from TEP stock, if not in stock please supply a quote. Attach quote/s for non-stock items.  If prescribing equipment from multiple sub-type please separate below. | | | | | | | | |
| **Item** | **Qty** | | **Equipment** | **Item description** (specific model &/or specifications required) | **‘T’/’H’No** | **Stock** | **Supplier details & Quote**  **(if applicable)** | **Clinical Priority** | |
| 1 |  |  | |  | T |  |  |  | |
| 2 |  |  | |  | T |  |  |  | |
| 3 |  |  | |  | T |  |  |  | |
| 4 |  |  | |  | T |  |  |  | |
| 5 |  |  | |  | 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. | | | | | | | | | |

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| 5. 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:  Freight Company (if known): Click or tap here to enter text.  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: | |

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| **6. 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):* |

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| **7. Resources** | | | | | | |
| **Pressure Management Equipment** | | | | | | |
| Waterlow Pressure Ulcer Risk Assessment Tool **OR** | ☐ | Yes | ☐ | No | Score: | Level of Risk: |
| Braden Scale for Predicting Pressure Sore Risk | ☐ | Yes | ☐ | No | Score: | Level of Risk: |
| Comment: | | | | | | |

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| **8. Prescriber Details** | | | | | | |
| ⏵ Print and Sign to Complete | | | | | | |
| 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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| **9. 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](mailto: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](mailto:topendintake.THS@nt.gov.au)  A: PO Box 40596,  Casuarina NT 0811 |

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