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| Please nominate the equipment this prescription is for:  Level 2 General or Seating Equipment - **COMPLETE ALL SECTIONS**  Any item that is not on the TEP Approved Equipment List - **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: | | | | | |  | | | | | | | | |
| 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:  The client will use the aid or device in order to participate in required functional activities; **AND**  The item facilitates the client’s primary means of communication or client is a mixed user; **AND**  Full participation cannot be achieved without the aid or device; **AND**  A plan for training and support for the aid or device use is in place.  Client must have a diagnosed communication impairment and be able to use the aid/device to facilitate communication. |

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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 device such as deterioration or improvement in condition, physiological issues, medications or planned surgery, growth, and/or weight.* | | | |
| **Social/Carer Factors** | | | |
| What are the implications for the client and/or carer if this equipment is not provided? | | | |
| Is the client or other relevant users (carers/attendant care workers/others) capable of using the equipment safely and appropriately? | Yes | No | N/A |
| Are the client’s carers and primary communication partners able to support the client’s use of the equipment? | Yes | No | N/A |
| Will the client and/or the support people who assist the client be trained to operate, program, charge and maintain the equipment appropriately? | Yes | No | N/A |
| If applicable, will the client and/or support people be able to use mounting systems for the equipment and or access method accurately? | Yes | No | N/A |
| Will the client and/or the support people who assist the client have adequate resources to prepare material and to program the equipment appropriately for functional use? | Yes | No | N/A |
| Will the client and/or the support people who assist the client have adequate resources to familiarise new communication partners with the equipment? | Yes | No | N/A |
| Is a plan for training to be made for the client, and if applicable the carer, regarding the use of the equipment, maintenance, cleaning and ongoing review? | Yes | No | N/A |
| Is a plan for training to be made for the client, and if applicable the carer, regarding equipment trouble shooting? | Yes | No | N/A |
| Is the carer able to hear and/or understand the speech output when the equipment is being used? | Yes | No | N/A |
| *If No to any of the above please explain*: | | | |
| **Environmental and Equipment Factors** | | | |
| Is the equipment compatible with current equipment being used? | Yes | No | N/A |
| For communication software, does the client own a device such as laptop/ PC/*iPad*/tablet with the minimum requirements required to run the software? | Yes | No | N/A |
| Is the equipment compatible with the environment (including storage)? | Yes | No | N/A |
| For systems with complex access, positioning or mounting requirements, has input from an occupational therapist been obtained? | 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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| Please attach any relevant correspondence from a specialist Alternate and Augmentative Communication (AAC) or Speech Generating Device (SGD) provider that has been sought to assist with trial selection and prescription. | | |

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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’ if issued from TEP stock. 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 |  |  |  |
| 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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| **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:  Contact person:  Phone number:  Email address: |
| ☐ Prescriber to deliver  ☐ Equipment already delivered – TEP Receipt and Acknowledgement (EI-R) MUST be attached  ☐ Other, give details: | |
| *Special instructions (eg. dogs, telephone prior to delivery, instructions re equipment for replacement, settings 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 DEPTEP 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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| 8. 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 and Years of Experience: | |  |
| 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 DEP TEP Cost Centre Manager approval)  All Items / Only Items 1 / 2 / 3 / 4 / 5 / Other:       (please circle) | **Not Approved** |

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| Provide brief rationale: | | |
| Name: | Title: | |
| Signature: | | Date:    /    / |
| Post/email completed forms 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 and the 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:** 01/02/2021 | | **Review Date:** 01/02/2024 |