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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**If completing multiple Prescription Forms for Multiple Equipment Types do not complete section 1B –**ATTACH P-C PRESCRIPTION COVERSHEET** |
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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 (Financial Hardship)* |
| 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:**For Toileting Aids:**[ ]  Client is unable to access toilet and/or perform toileting tasks without support; **AND**[ ]  Provision of aids allows client to perform toileting tasks safely or independently.**For Showering Aids:**[ ] Client is unable to stand in shower or sit in bath without support; **AND**[ ]  Provision of aids allows client to perform self-care activities safely or independently.**For Transfer Aids/Lifting Devices:**[ ]  Client is unable to transfer safely and independently; **OR**[ ]  Transfers assisted by carers are unsafe, ineffective or pose a risk of injury to carers; **AND**[ ]  The item is required for the majority of transfers.**For Miscellaneous items:**[ ]  Client is unable to transfer safely and independently using current available seating; **OR** [ ]  Transfers assisted by carers are unsafe, ineffective or pose a risk of injury to carers; **AND**[ ]  A standard chair can not be raised or modified to meet the client’s assessed need.**OR**[ ]  Client is unable to mobilise safely and independently; **AND**[ ]  The equipment will allow the client to perform a functional task independently. |

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| **3. Equipment Decision and Justification** (Please refer to Clinical Guidelines) |
| 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 |
| *If No to the above please explain*:      |
| **Environmental and Equipment Factors** |
| Is the equipment compatible with current equipment being used? | [ ]  Yes | [ ]  No  | [ ]  N/A |
| Is the transfer device compatible with planned new equipment? | [ ]  Yes | [ ]  No  | [ ]  N/A |
| Is the equipment compatible with the clients: |
| * Functional level?
 | ☐ Yes | ☐ No  | ☐ N/A |
| * Weight and size, confirm SWL of equipment ?
 | ☐ Yes | ☐ No  | ☐ N/A |
| * Transfers?
 | ☐ Yes | ☐ No  | ☐ N/A |
| For mobile commodes, was a home visit completed to assess access into/out of bathroom, including sufficient clearance over and around the toilet? | ☐ Yes | ☐ No  | ☐ N/A |
| For hoists, is the sling compatible with the hoist? | ☐ Yes | ☐ No  | ☐ N/A |
| Is the equipment compatible with the environment in all relevant rooms (eg. sufficient space to use the equipment, move through doorways)? | ☐ Yes | ☐ No  | ☐ N/A |
| Is there provision for storage and/or charging of equipment? | ☐ 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 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 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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| **8. Resources** |
| Please attach relevant Resources for this prescription. Refer to Clinical Guidelines Aids for Daily Living - 2a, 2b, 2c and 2d. |
| **For Pressure Care** |
| 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:       |
| **If required**, for **Customised Mobile Commode**  |
| Customised Mobile Commode Templates (as per product requirements) | ☐ | Yes | ☐ | No |
| Comment:       |

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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: TEPAdmin 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.auA: PO Box 721,  Alice Springs NT 0871 | **Top End** *(includesDarwin rural area, Katherine, East Arnhem)*E: topendintake.THS@nt.gov.auA: PO Box 40596, Casuarina NT 0811 |

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