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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:  **For Bed Accessories:**  Bed accessories are required by client to perform ADL tasks or transfers independently; **AND/OR**  Clinical diagnosis requires specific positioning in bed; **AND/OR**  Equipment is required to ensure safety of client in bed.  **For Hospital Bed:**  The use of static and other bed accessories have been considered and/or trialled and are not suitable; **AND**  Must be critical to the continuation of the client’s care at home; **AND/OR**  An adjustable hospital bed is required by the client to perform pertinent ADL tasks independently; **AND/OR**  Clinical diagnosis requires specific positioning in bed AND the client is unable to transfer or change position in bed without the equipment; **AND/OR**  Variable heights are required for the safe provision of care OR transfers; **AND/OR**  Modifications or adaptations to a standard bed cannot achieve the recommended results.  **For Night-time Positioning Equipment :**  ☐ This equipment is the clien’ts primary means of lying postural support and positioning; AND/OR  ☐ The use of postural support and positioning equipment can be clinically demonstrated to prevent the development of progressive, functionally limiting, contracture and deformity. |

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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 including set up, transfers, use of controls and brakes? | Yes | No | N/A |
| Are carers in agreement with using equipment (eg. additional bed/bedding for a partner without a disability will not be funded through TEP)? | Yes | No | N/A |
| Is there a plan for training carers in the use, maintenance, cleaning and ongoing review of the equipment | Yes | No | N/A |
| *If No to any of the above please explain:* | | | |

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| **Environmental and Equipment Factors** | | | |
| Is the equipment compatible with current equipment being used? | Yes | No | N/A |
| Is the equipment compatible with planned new equipment (eg. hoist)? | Yes | No | N/A |
| Is the equipment compatible with the client’s: | Yes | No | N/A |
| * Functional level? | Yes | No | N/A |
| * Weight and size, confirm SWL of equipment (bariatric considerations)? | Yes | No | N/A |
| * Transfers? | Yes | No | N/A |
| Is the equipment compatible with the home environments – can it be set up in the preferred room? | Yes | No | N/A |
| Is there adequate circulation space for client and/or carers? | Yes | No | N/A |
| Can the client use the equipment safely? | Yes | No | N/A |
| For an electric bed is there an adequate, accessible power supply? | 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 pleaser supply a quote. Attach quote/s for non stock items.  If prescribing equipment from **multiple** sub-types **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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| **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 Acknowlegdement (EI-R) MUST be attached  ☐ Other, give details: | |
| *Special instructions (eg. dogs, telephone prior to delivery, instructions re equipment for replacement, settings etc):* | |

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| 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** |
| Not applicable for this Equipment Type |

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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 DEP 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 DEP 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 and the rural area, Katherine, East Arnhem)*  E: topendintake.THS@nt.gov.au  A: PO Box 40596,  Casuarina NT 0811 |

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