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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**  This form is to be used where Wheeled Mobility aids AND / OR Pressure Management Equipment is being prescribed at the same time.  **Please nominate the equipment types this prescription is for:**  ☐ **Wheeled Mobility Aids**  ☐ **Pressure Management Equipment** | | | | | | | | | | | | |
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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:  **Manual Wheelchair:**  ☐ Client is unable to walk safely to achieve their functional goals; **AND**  ☐ A wheelchair is the client’s primary means of mobility; **OR**  ☐ Client is a mixed mobility user; **AND**  ☐ Client or carer is able to propel the chair safely.  **Powered Wheelchair :**  ☐ Client is unable to walk or propel a manual wheelchair safely to achieve independent mobility and achieve their functional goals; **AND**  ☐ A powered wheelchair is the client’s primary means of mobility; **OR**  ☐ Client meets the guidelines as a mixed mobility user; **AND**  ☐ It has been established that the client or carer has the cognitive, physical and psychological capacity to safely and effectively use the equipment.  **Pressure Management Equipment:**  ☐ Client is at risk of a pressure area as evidenced by a validated pressure area risk assessment tool in conjunction with clinical reasoning; **AND**  ☐ Client’s pressure area risk is unlikely to significantly change; **AND**  ☐ The risk cannot be managed by other pressure management techniques and/or equipment. |

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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) able to use the equipment safely and appropriately including transfers, propulsion, set up, care and troubleshooting? | Yes | No | N/A |
| Is there a plan for training carers in the use of the wheeled mobility aid, including folding, transport, maintenance, cleaning and ongoing review? | Yes | No | N/A |
| Is there a plan for training carers in the use, maintenance, cleaning and ongoing review of the positioning and / or pressure management equipment? | 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 (e.g. hoist, bed, hi-lo bed, bed rails, wheelchair)? | Yes | No | N/A |
| Is the equipment compatible with planned new equipment (e.g. seating system, wheelchair)? | Yes | No | N/A |
| Is the equipment compatible with the client’s: | Yes | No | N/A |
| * Functional level? * Mobility needs? | Yes | No | N/A |
| * Weight and size, confirm SWL of equipment? | Yes | No | N/A |
| * Transfers (consider seat height, armrests, footplates, sling etc)? | Yes | No | N/A |
| * Environment of use (consider type of tyres, wheels, castors)? | Yes | No | N/A |
| * Mode of transport? | Yes | No | N/A |
| Is the equipment compatible with the home and other environments of use, including internal access to rooms, passageways, circulation space/turning circle, floor surfaces, table heights at home, external access to the home (eg. ramps)? | Yes | No | N/A |
| Is there a lockable and waterproof environment for storage of manual/powered wheelchair? | Yes | No | N/A |
| Is there a power point available and does the home have a electrical safety switch for charging of powered wheelchair? | Yes | No | N/A |
| Has consideration been given to removing items which may reduce the effectiveness of the pressure care equipment such as continence aids (pads/blueys/kylies etc), non-stretch bed sheets, sheepskins? | Yes | No | N/A |
| Can the client use the equipment safely? | Yes | No | N/A |
| Has client been advised that other mobility equipment may need to be returned on issue of the wheeled mobility aid (eg. equipment being replaced by this prescription)? | Yes | No | N/A |
| Has the client been advised that the ownership of the equipment will be transferred to the client if admitted to a high level Residential Aged Care Facility, becomes in receipt of a Commonwealth Home Care Package or becomes a National Disability Insurance Scheme (NDIS) participant? | 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. 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. Please note that all Level 2 General equipment needs to be delivered and fitted with the prescribing or treating therapist present.  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  ☐ 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. | | | | | |
| **Resources for manual wheelchair attached:** | | | | | |
| Client Measurement Chart |  | Yes |  | No |
| Manufactures script/order form |  | Yes |  | No |
| **Required resources for powered wheelchair attached:** | | | | | |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Cognitive screen |  | Yes |  | No | | | | Vision assessment | ☐ | Yes | ☐ | No | | | | Driving assessment |  | Yes |  | No | | | | Medical Clearance |  | Yes |  | No | | | | Client Measurement Chart |  | Yes |  | No | | | | Manufacturers script/order form |  | Yes |  | No | | | | **Required resources for pressure management equipment attached:** | | | | | | | | 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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| **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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