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| --- |
| On initial delivery please ensure this form is completed and returned to the Territory Equipment Program.  |
| NT Department of Health TEP |[ ]  *Account No.*      |
|  |
| **Deliver Equipment to Client** |[ ]  **Collect Equipment from Client** |[ ]   |  |
| **Other** |[ ]   |
|  |
| **Client Details** | **Client ID:** |  |
| Given Names: |       | Surname: |       |
| Address: |       | Phone: |       |
| Contact Persons Name: *(if different to client)* |       |
| **Equipment/Gas Required** | **✓** | **Comments/No. of Cylinders Required** |
| Kit A Concentrator |[ ]        |
| Portable Oxygen Concentrator  |[ ]        |
| C Cylinder |[ ]        |
| CD Cylinder |[ ]        |
| Trolley for cylinder  |[ ]        |
| Other (specify):  |[ ]        |
| Flow Rate |[ ]        |
| Number of cylinder refills per week: | 1 |
| Additional Comments/Instructions:  |
|  |
| **Work Health and Safety** |
| Ground level house/flat |[ ]  Upstairs house/flat |[ ]  Other (please specify above) |[ ]
|  |
| **Prescriber Details** |
| Name: |       | Title: |       |
| Signature: |  | Date: |    /    /      |

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