|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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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| --- | --- | --- | --- |
| **PGC/SharePoint ID:** HEALTHINTRA-1880-9466 | | **PGC/Content Manager ID:** EDOC2018/44299 | |
| **Version Number:** | Version: 11.0 | | **Approved Date:** 20/12/2021 | | **Review Date20/12**/2024 |