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| Please nominate the equipment this prescription is for:  ☐ Minor (Level 1) Home Modifications – **COMPLETE ALL SECTIONS**  ☐ Major (Level 2) Home Modifications - **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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| 1a. Client Details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Client ID: | | | | |  | | | | | | | Is the applicant an existing TEP client? | | | | | | | | | | | | | | | | | ☐ Yes | | ☐ No | | ☐ Unsure | | |
| 1b. Further Client Details(Required for single Equipment Type prescription only) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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): | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. Identification of Need/Clinical Criteria | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Client diagnosis: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please ‘check’ as relevant:  ☐ Client is unable to access the house or areas of the house due to structural barriers **AND/OR**  ☐ Modification would increase the client’s safety and independence and/or the carer’s safety. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. Equipment Decision and Justification(Please refer to Clinical Guidelines) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Client Factors | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please provide information on clients functional impairment and clinical justification for home modifications being prescribed; | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is any change anticipated that may impact on the home modification request? | | | | | | | | | | | | | | | | | | | | | | | | | | ☐ Yes | | | | | | ☐ No | | | ☐ N/A |
| If Yes, please comment on how the equipment/modification will accommodate an anticipated change:  *For example, any relevant medical information that impacts on client’s current and ongoing ability to use the equipment/modification such as deterioration or improvement in condition, physiological issues.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Social/Carer Factors | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What are the implications for the client and/or carer if this home modification is not provided? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has home ownership been determined – privately owned, privately rented or public/community housing? | | | | | | | | | | | | | | | | | | | | | | | | | ☐Privately owned  ☐ Privately rented  ☐ Public/community housing | | | | | | | | | | |
| Environmental and Equipment Factors | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is the home modification compatible with current equipment being used? | | | | | | | | | | | | | | | | | | | | | | | | | ☐ Yes | | | | | | | ☐ No | | | ☐ N/A |
| Is the residence structurally sound and in good condition? | | | | | | | | | | | | | | | | | | | | | | | | | ☐ Yes | | | | | | | ☐ No | | | ☐ N/A |
| *Please comment on simpler optons already trialled or in place such as non-structural modificatons, use of equipment or modified behavioural techniques:* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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. For recycled rubber ramps 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 if issued from TEP stock, if not in stock please 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) | | | | | | | | **Stock** | | | | | **Supplier details & Quote** (if applicable) | | | | | | | | | | | **Clinical Priority** | |
| 1 |  | | | | |  | | | |  | | | | | | | |  | | | | |  | | | | | | | | | | |  | |
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| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is a client contribution required? ☐ Yes ☐ No | | | | | | | | | | | | | | | | | | If Yes, is the client/guardian aware? ☐ Yes ☐ No | | | | | | | | | | | | | | | | | |
| TOTAL COST (including GST) | | | | | | | | | | | | | | $ | | | | | | | | | | | | | | | | Name of third party contributor and their agreed contribution amount (if applicable): | | | | | |
| less  Maximum Subsidy/TEP Contribution | | | | | | | | | | | | | | $ | | | | | | | | | | | | | | | |
| equals  Client Contribution | | | | | | | | | | | | | | $ | | | | | | | | | | | | | | | |
| 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  ☐ Other, give details: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Special instructions (eg. dogs, telephone prior to delivery, instructions re equipment for replacement, height/settings etc):* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. Equipment Review | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| It is the prescribing therapist’s responsibility to ensure correct fitting and client education for TEP equipment on issue.  The Approved Prescriber must undertake a review of all Major (Level 2) Home Modifications, to ensure correct positioning and achievement of objectives and to complete required resources.  Please indicate mode of review arranged for equipment/home modification:  ☐ Home visit ☐ Telephone Call ☐ Client to contact prescriber as needed  ☐ Other *(state details of referral made for follow up, as required):* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. Resources | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please attach relevant Resources for this prescription. Refer to Clinical Guidelines.  **Required** Resources for a **Minor (Level 1) Home Modification** (excluding portable ramps) attached: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TEP HD Home Modification Diagram | | | | | | | | | | | | | | | | | | | | ☐ | | Yes | | | | | | ☐ | | No | | | | | |
| TEP GR-D Grab Rail Disclaimer Form | | | | | | | | | | | | | | | | | | | | ☐ | | Yes | | | | | | ☐ | | No | | | | | |
| TEP GR-C Grab Rail Owner Landlord Consent (as required) | | | | | | | | | | | | | | | | | | | | ☐ | | Yes | | | | | | ☐ | | No | | | | | |
| **Required** Resources for a **Major (Level 2) Home Modification** attached: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TEP HD Home Modification Diagram | | | | | | | | | | | | | | | ☐ | Yes | | | ☐ | | | | | No | | | | | | | | | | | |
| Comment: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please note the Resources to be submitted to TEP **following approval** and at **completion of works** as per Clinical Guidelines. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| 9a. Prescriber Details | | | | | | | | | | | |
| ⏵ Print and sign to complete | | | | | | | | | | | |
| 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: | | |  | |
| 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: | |
| **Top End**  (includes Darwin and the rural area, Katherine, East Arnhem)  E: topendintake.THS@nt.gov.au  A: PO Box 40596,  Casuarina NT 0811 | **Central Australia**  (includes Alice Springs, Remote Barkly)  E: centralaustraliaintake.THS@nt.gov.au  A: PO Box 721,  Alice Springs NT 0871 |

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