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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ☐ This prescripton is for trial of 1 month supply (e.g. 1 Carton)  ☐ This prescription is for 12 months. (For re-order every 3 months)  ☐ This prescription is for a once only order | | | | | | | | | | | | | |
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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  (Delivery to be made to): | | | | |  | | | | | | | | |
| Parent/Guardian (if applicable): | | | | |  | | | | | | | | |
| Contact Details (if different): | | | | |  | | | | | | | | |
| **2. Identification of Need/Clinical Criteria** | | | | | | | | | | | | | |
| Client Diagnosis and Details of Functional Impairment: | | | | | | | | | | | | | |
| Please ‘check’ as relevant:  ☐ Client has a permanent moderate to severe incontinence; **AND**  ☐ Equipment needs greater than would be covered by the Continence Aids Payment Scheme (CAPS) funding for clients eligible for CAPS; **OR**  ☐ Client is not eligible for CAPS. | | | | | | | | | | | | | |
|  **Delivery plan** – to go at the back. See section 5 | | | | | | | | | | | | | |

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| **3. Equipment (Product) Recommendation** | | | | | | | | |
| **NOTE: If products recommended are not on contract, please provide clinical justification for their purchase in Section 4. Refer to NTG Procurement policies and and guidelines for further details.** | | | | | | | | |
| **PADS** | | | | |  | | | |
| **Pullup pants** | | | | | | | | |
| **SUPPLIER** | | **Product CODE** | | **PRODUCT – Trade Description** | **Unit per carton** | **$ per carton** | **QTY** | **Contract**  **Y/N** |
|  | |  | |  |  |  |  |  |
|  | |  | |  |  |  |  |  |
| **All in One .SEVERE TO VERY SEVERE INCONTINENCE…...Amounts shown are total capacity NOT comfort capacity** | | | | | | | | |
|  | |  | |  |  |  |  |  |
|  | |  | |  |  |  |  |  |
| **Light Incontinence pads HEAVY TO SEVERE INCONTINENCE….. Amounts shown are total capacity NOT comfort capacity** | | | | | | | | |
|  | |  | |  |  |  |  |  |
|  | |  | |  |  |  |  |  |
| **2-piece anatomical shaped pads. Amounts shown are total capacity NOT comfort capacity** | | | | | | | | |
|  | |  | |  |  |  |  |  |
|  | |  | |  |  |  |  |  |
| **NAPPIES** | | | | |  | | | |
| **SUPPLIER** | | **Product CODE** | | **PRODUCT – Trade Description** | **Unit per carton** | **$ per carton** | **QTY** | **Contract**  **Y/N** |
|  | |  | |  |  |  |  |  |
|  | |  | |  |  |  |  |  |
| **Bed pads – Under Pads** | | | | | | | | |
|  | |  | |  |  |  |  |  |
|  | |  | |  |  |  |  |  |
| **CATHETERS** | | | | |  | | | |
| **Intermittent catheters** | | | | | | | | |
| **SUPPLIER** | | **Product CODE** | | **PRODUCT – Trade Description** | **Unit per box** | **$ per box/unit** | **QTY** | **Contract**  **Y/N** |
|  | |  | |  |  |  |  |  |
|  | |  | |  |  |  |  |  |
| **Indwelling catheters** | | | | | | | | |
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|  | |  | |  |  |  |  |  |
| **URIDOMES** | | | | |  | | | |
| **SUPPLIER** | | **Product CODE** | | **PRODUCT – Trade Description** | **Unit per box** | **$ per box** | **QTY** | **Contract**  **Y/N** |
|  | |  | |  |  |  |  |  |
|  | |  | |  |  |  |  |  |
| **BAGS** | | | | |  | | | |
| **Drainage bags overnight & leg** | | | | | | | | |
| **SUPPLIER** | | **Product CODE** | | **PRODUCT – Trade Description** | **Unit per box** | **$ per box** | **QTY** | **Contract**  **Y/N** |
|  | |  | |  |  |  |  |  |
|  | |  | |  |  |  |  |  |
| **MISCELLANEOUS** | | | | |  | | | |
| **Retention pants** | | | | | | | | |
| **SUPPLIER** | **Product CODE** | | **PRODUCT – Trade Description** | | **Unit per box** | **$ per box** | **QTY** | **Contract**  **Y/N** |
|  |  | |  | |  |  |  |  |
|  |  | |  | |  |  |  |  |
| **Gloves** | | | | | | | | |
|  |  | |  | |  |  |  |  |
|  |  | |  | |  |  |  |  |
| **Other** | | | | | | | | |
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| **4. Procuring Products Off Contract** |
| Please provide clinical justification for purchase of products which are not listed on NT Health contracts. |

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| **5. 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:  Freight Company (if known):  Community clinic or Aged Care Centre:  Contact person:  Phone number:  Email address: |
| ☐Prescriber to deliver  ☐ Other, give details: | |

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| **6. Prescriber Details** | | | | | | |
| Prescriber Name: | |  | Approved Prescriber No.: | | |  |
| Qualification: |  | | Email: |  | | |
| Work Unit: |  | | Contact Number: | |  | |
| ☐ 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:    /    / | | | |

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| **7. Endorsement** (As required) | | | | | | | | |
| Endorsed by Approved Prescriber Name: | | | |  | | | | |
| Approved Prescriber No: | | |  | | Qualification: | |  | |
| Work Unit: | |  | | | Contact Number: | | |  |
|  |  | | | | | | | |
| ☐ 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:    /    / | | | |
| **8. 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** | | | | | | ☐ **Not Approved** | | |
| If not approved, provide brief rationale: | | | | | | | | |
| Name: | | | | | | Title: | | |
| Signature: | | | | | | Date:    /    / | | |
| Completed forms should be posted or emailed to: | | | | | | | | |
| **Top End**  *(includes Darwin rural area, Katherine and 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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