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| Please complete all sections | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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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.): | | | | |  | | | | | | | | *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: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Postal Address (if different): | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Parent/Guardian (if applicable): | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Contact Details (if different): | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Client Diagnosis and Details of Condition/Functional Impairment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. Identification of Need/Clinical Criteria | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| State the clinical criteria that relates to this equipment request:  *Provide information from the clinical and functional assessment of relevant skills including physical, sensory and cognitive considerations* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please ‘check’ as relevant:  Adherence to ANZ Thoracic Guidelines for Eligibility | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. Equipment Decision and Justification(Please refer to Clinical Guidelines) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Client Factors | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provide **further** details, as relevant, from the clinical and functional assessment of relevant skills including physical, sensory and cognitive considerations such as:   * *Lifestyle issues* * *Clinical need for equipment* * *Ability to safely use this equipment in the home* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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) capable of using the equipment safely and appropriately? | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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 prescribed or in use? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | No | | | N/A | |
| Is the equipment compatible with the environment (including storage) | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | No | | | N/A | |
| *If No to any of the above, please explain*: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Any other relevant considerations:* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *List ALL relevant/related equipment currently being used (including low-technology communication systems):* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. 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.  If prescribing equipment from **multiple** sub-types **please separate below.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Item** | **Qty** | | **Equipment Sub-Type** | | | | | | | | **Item description** (specific model &/or specifications required) | | | | **TEP No.** | | | | **Model / Item No.** | | | | **Stock or Supplier details** | | | | | | | | | **Quote** ($) | | | | **Clinical Priority** |
| *Eg* | *1* | | *Concentrator* | | | | | | | |  | | | | *N/A* | | | | *N/A* | | | | *stock* | | | | | | | | | *N/A* | | | | *1* |
| 1 |  | |  | | | | | | | |  | | | | T | | | |  | | | |  | | | | | | | | |  | | | |  |
| 2 |  | |  | | | | | | | |  | | | | T | | | |  | | | |  | | | | | | | | |  | | | |  |
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| 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is the client/guardian aware of, and in agreement with, this equipment recommendation?  Yes  No *If No, please state why:* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is a client contribution required?  Yes  No | | | | | | | | | | | | | | | | If Yes, is the client/guardian aware?  Yes  No | | | | | | | | | | | | | | | | | | | | |
| TOTAL COST (excluding GST and freight) | | | | | | | | | | | | | | $ | | Name of third party contributor and their agreed contribution amount (if applicable): | | | | | | | | | | | | | | | | | | | | |
| less  Maximum Subsidy/TEP Contribution | | | | | | | | | | | | | | $ | |
| equals  Client Contribution | | | | | | | | | | | | | | $ | |
| 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  Prescriber to deliver  Other*, give details:* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Special instructions (eg. dogs, telephone prior to delivery, instructions re equipment for replacement, settings etc):* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. 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):* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. Resources | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Not applicable for this Equipment Type | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. Prescriber Details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ⏵ Print and sign to complete | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Prescriber Name: | | | | | | |  | | | | | | | | | | | Approved Prescriber No: | | | | | | | | | | |  | | | | | | | |
| Qualification: | | | | | | | |  | | | | | | | | | | Email: | |  | | | | | | | | | | | | | | | | |
| Work Unit: | | | | | | | |  | | | | | | | | | | Contact Number: | | | | | | | | |  | | | | | | | | | |

*\*Please note that supply of oxygen and respiratory applicances in the Top End, including Darwin Urban and Remote, Katherine and East Arnhem is managed by Royal Darwin Hospital (RDH). Contact the Community Respiratory Nurse, RDH for further details. Contact: (08) 8985 8158 email:* [*RespNurses.DOH@nt.gov.au*](mailto:RespNurses.DOH@nt.gov.au)

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| 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:    /    / | |
| 9. Endorsement(As required) | | | | | |
| Endorsed by Respiratory Medical Specialist (name): | | |  | | |
| Title/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:    /    / | |
| 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)*  P: 08 8951 6747 E: centralaustraliaintake.THS@nt.gov.au  A: PO Box 721, Alice Springs NT 0871 | | | | | |

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