Compression Garment Request Form

This form should be used to request the first order of compression garments and amended requests. Refer to the Funding Criteria [here](#) for information regarding eligible persons, eligible prescribers and equipment provided.

1. PERSONAL INFORMATION

<table>
<thead>
<tr>
<th>Name</th>
<th>Last Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Suburb &amp; Post Code</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Title</th>
<th>Mr</th>
<th>Mrs</th>
<th>Ms</th>
<th>Miss</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of birth:</th>
<th>Phone</th>
<th>Mobile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternative Contact person</th>
<th>Relationship</th>
<th>Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Diagnosis

Type of Lymphoedema:

- □ 1° Lymphoedema  
- □ 2° Lymphoedema  
- □ Venous insufficiency  
- □ Lipoedema  
- □ Other

Location of Lymphoedema:

- □ Left Upper Limb  
- □ Right Upper Limb  
- □ Left Lower Limb  
- □ Right Lower Limb  
- □ Truncal Lymphoedema of the  
  - □ Chest  
  - □ Back  
  - □ Abdomen  
  - □ Buttocks  
  - □ Breast  
  - □ Genital  
- □ Head and Neck

Severity of Lymphoedema:

- □ Mild  
- □ Moderate  
- □ Severe

Symptoms

- □ Swelling  
- □ Heaviness  
- □ Numbness  
- □ Tightness  
- □ Pain  
- □ Skin changes  
- □ Pins and needles  
- □ Reduced mobility  
- □ Functional limitation  
- □ Other

2. COMPRESSION GARMENT RECOMMENDATION

<table>
<thead>
<tr>
<th>Product Code</th>
<th>Description</th>
<th>Supplier</th>
<th>Quantity Each</th>
<th>Quantity Pair</th>
<th>Cost</th>
<th>Contract / Quote #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RTW Custom</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RTW Custom</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RTW Custom</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RTW Custom</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RTW Custom</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

Specify quantity and cost per affected body part per 6 months. New quote is required every 6 months if applicable. Quantities / Quote should reflect order for 6 months. Indicate cost per garment or per pair of garments. RTW = Ready to wear.
3. IDENTIFICATION OF NEED

(a) **Goal of compression garment provision (tick all that apply):**
- [ ] Assist person to perform activities of daily living
- [ ] Assist person to wear clothes and dress independently
- [ ] Assist person to wear shoes
- [ ] Assist person to mobilise safely
- [ ] Assist with bed mobility and transfers
- [ ] Reduce the risk of falls
- [ ] Other

(b) **How often will the compression garment(s) be used?**
- [ ] Continuously every day
- [ ] Other (please describe)

4. COMPRESSION GARMENT JUSTIFICATION

(a) **Date of assessment**

(b) **Describe the person’s need for this equipment.**
- [ ] Reduce and maintain swelling and other lymphoedema symptoms
- [ ] Other

AND person’s oedema is now stable as:
- [ ] Swelling is minimised
- [ ] Pitting oedema is absent or minimal
- [ ] Shape distortion has been optimized
- [ ] Other

(c) **Additional clinical justification if custom made or non-contract items are requested**

(d) **Compression garment provision and ongoing care**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Person/carer is aware of supply allocation through EnableNSW and how they can purchase additional supplies as required</td>
<td>Yes</td>
</tr>
<tr>
<td>Person is compliant with wearing compression garments</td>
<td>Yes</td>
</tr>
<tr>
<td>Person/carer is capable of using compression garments safely and appropriately</td>
<td>Yes</td>
</tr>
<tr>
<td>Person /carer understands how to care and maintain compression garments</td>
<td>Yes</td>
</tr>
<tr>
<td>Person /carer has the ability to seek assistance from clinician as required</td>
<td>Yes</td>
</tr>
<tr>
<td>Person /carer has details of local contact for ongoing clinical management if person is being discharged to another area</td>
<td>Yes</td>
</tr>
<tr>
<td>Please provide name and contact details of local contact</td>
<td>Yes</td>
</tr>
</tbody>
</table>
## 5. TRIAL OUTCOMES

- Has the prescribed compression garment(s) been trialed? [Yes] [No]  
  Duration of trial
- Has the trial of the prescribed compression garment(s) been successful? [Yes] [No]
- Describe how each feature/specification of the recommended compression garment(s) will meet the person’s needs in the most cost effective, clinically appropriate way
- Has person trialled other compression garment(s) previously? [Yes] [No]
  If yes, provide more information on the outcome of the trial:

## 6. DELIVERY INFORMATION

(a) Special instructions when funding approved:
- Prescriber to be informed as person needs to be re-measured
- Place order as re-measure not required

(b) Who should be notified when the compression garment(s) is/are ready to be delivered?
- Person/Carer
- Prescriber
- Other. Provide contact name, relationship, phone, email

(c) Delivery address for compression garment(s):
- Person’s home address
- Prescriber’s workplace address:
- Other, provide details and reasons

## 7. PRESCRIBER DECLARATION (Tick all that apply)

- I confirm that the person/carer is in agreement with this request
  - A copy of this request has been provided to person/carer [Yes] [No]
- I understand that all information I have supplied on this application is true and correct to the best of my knowledge at the time of assessment
- I declare that I have assessed the person and have the required qualification and level of experience to prescribe this equipment according to the Professional Criteria for Prescribers and have
  - Completed Level 1 Lymphoedema Management Course (recognised by the Australasian Lymphology Association)
  OR
  - I declare that I have assessed the person and I have been supervised by who is an eligible prescriber and has agreed to be nominated as my supervisor for this prescription
- I have read and understand my responsibilities and obligations as provided in the declaration above
<table>
<thead>
<tr>
<th>Prescriber name:</th>
<th>If applicable:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualification:</td>
<td>Supervisor name:</td>
</tr>
<tr>
<td>AHPRA Registration Number:</td>
<td>Qualification:</td>
</tr>
<tr>
<td>Phone:</td>
<td>AHPRA Registration Number:</td>
</tr>
<tr>
<td>Email:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Name of Service:</td>
<td>Email:</td>
</tr>
<tr>
<td>Days/Hours available:</td>
<td>Name of Service:</td>
</tr>
<tr>
<td>Date:</td>
<td>Days/Hours available:</td>
</tr>
</tbody>
</table>

Note: Incomplete forms will not be processed. Please ensure all correct details are provided.

Please email requests from a work email address to: enable@health.nsw.gov.au

Thank you