# Continence
## Equipment Request Form

A Consumer application form is also required

☐ **New Request** ☐ **Amended Request**

**1. PERSONAL INFORMATION**

| | | | |
|---|---|---|---|
| **Name** | **Last Name**<br><br>**First Name** | **Address**<br><br>**Suburb & Post Code** | |
| **Title** | ☐ Mr ☐ Mrs ☐ Ms ☐ Miss<br>☐ Other | **Date of birth:** | |
| **Phone** | | **Mobile** | |
| **Alternative Contact person** | | **Contact details** | |
| **Bladder and/or Bowel Diagnosis:**<br><br>☐ **Urinary incontinent**<br>☐ **Faecal incontinent**<br>☐ **Bladder dysfunction** | | **Other medical/health conditions/diagnoses that relate to this request:** | |

**Does person have permanent and moderate to severe incontinence?** ☐ **Yes** ☐ **No**

**Does person receive CAPS funding?** ☐ **Yes** ☐ **No** **if no, why?**

Has the person's discharge date and destination been confirmed? ☐ Yes ☐ No ☐ N/A
If no please provide details

**2. EQUIPMENT RECOMMENDATION**

**For amended requests please indicate the items to be deleted and the new items to be added**

* Actual allocation may vary depending on packaging. Please see Continence Funding Criteria for available annual allocations and required clinical justification for non standard supply.

*Supplier details are only required for non contract items*

| Add | Del | Product Name | Product Code | Supplier | Standard allocation* | Quantity Requested |
|---|---|---|---|---|---|---|
| ☐ | ☐ | **Urinary or Faecal Incontinence** | | | **810** | |
| ☐ | ☐ | Pads/Pullups/Slips/Nappies | | | ☐ 810 | |
| ☐ | ☐ | Washable Pads/garments | | | ☐ 18 | |
| ☐ | ☐ | Sheaths/Uridomes | | | ☐ 270 or ☐ 2 re-usable | |
| ☐ | ☐ | **Urinary and Faecal Incontinence** | | | **1080** | |
| ☐ | ☐ | Pads/Pullups/Slips/Nappies | | | ☐ 1080 | |
| ☐ | ☐ | Washable pads/garments | | | ☐ 24 | |

Name:
Date of Birth:

| Add | Del | Product Name | Product Code | Supplier | Standard allocation* | Quantity Requested |
|---|---|---|---|---|---|---|
| ☐ | ☐ | **Bladder Dysfunction** | | | | |
| ☐ | ☐ | Intermittent catheters (standard) | | | ☐ 600 | |
| ☐ | ☐ | Indwelling or Suprapubic catheters | | | ☐ 9 | |
| ☐ | ☐ | Reusable catheter sets | | | ☐ 3 sets | |
| | | **Drainage Equipment** | | | | |
| ☐ | ☐ | Leg bags | | | ☐ 36 | |
| ☐ | ☐ | Drainage bags | | | ☐ 36 | |
| ☐ | ☐ | Drainage bottles | | | ☐ 2 | |
| ☐ | ☐ | Drainage tubes | | | ☐ 6 | |
| ☐ | ☐ | Catheter Straps | | | ☐ 4 | |
| ☐ | ☐ | Catheter valves | | | ☐ 9 | |
| ☐ | ☐ | Adhesive catheter stabiliser | | | ☐ 1 box | |
| ☐ | ☐ | **Bowel Management** | **Name** | **Code** | **Supplier** | **Quantity Requested** |

**Are any changes anticipated that may impact on this equipment request?** ☐ No change anticipated ☐ Yes
People can request a change in size to pads/pullups/nappies without a re-assessment
In your clinical opinion, can person request a change on other products ☐ Yes ☐ No
If yes, provide circumstances and time frame in which change can be requested

## 3. EQUIPMENT JUSTIFICATION

**a) What is the client centred goal that relates to this continence equipment?**
☐ **Maintain renal health** ☐ **Maintain skin integrity** ☐ **Allow social inclusion** ☐ **Prevent leakage**
☐ **Other (please provide)**

**b) What assessments were conducted in determining need for this equipment?**

☐ Bladder assessment ☐ Indwelling catheter assessment ☐ Bowel assessment

☐ Neurogenic bladder/bowel assessment ☐ Other - Please list:

**c) Has the person used or trialled the recommended product?**

☐ Yes, How long or how many disposable items trialled?

☐ No If No, why?

**d) Are you requesting pads/slips/pullups for person > 5years old? ☐ Yes ☐ No**

If yes, how many pads does the person use in a 24 hour period?

Does the person require more frequent changes of pads due to faecal incontinence ☐ Yes ☐ No

**e) Are you requesting a non-standard catheter? ☐ Yes ☐ No**

If yes, provide clinical information regarding the outcomes from using standard catheters such as frequency of urinary/renal infections**.**

Please state frequency of catheterisation per day per month

Provide outcome of trial of catheter requested

Please provide name of medical specialist/continence advisor requesting

Is there supporting documentation from medical specialist/continence advisor attached ☐ Yes ☐ No

**f) Are you requesting a non-contract item? ☐ Yes ☐ No**

If yes, please provide clinical reasons that a contract item is unable to be used?

What contract items have been trialled and provide outcomes of the trials.

**g) Are you requesting a pads/pullups/nappies for a child < 5years old? ☐ Yes ☐ No**

**If yes,** does child have a Neurogenic bladder and bowel due to lower motor neuron condition ☐ Yes ☐ No

**If yes, go to question (h)**

**Has a toilet training program been undertaken?** ☐ Yes ☐ No

**If yes,** provide outcomes of participation in a toilet training program over 6 month period

Is supporting documentation from child's early intervention team/child care centre/school attached? ☐ Yes ☐ No

**If no,** explain the impact of the child's multiple disability or related health conditions on his/her ability to commence a toilet training program

**h) Are you requesting bowel management equipment? ☐ Yes ☐ No**

**If yes,** does child have anal sphincter deficit or neurological incontinence ☐ **Yes** ☐ **No**

**If yes,** is child/person on bowel washout regime with previous product trialled or replacement of product previously used

☐ **Yes** ☐ **No**

**If yes,** is person committed to ongoing out-of-pocket expenses to maintain bowel management program

☐ **Yes** ☐ **No**

Please provide name of medical specialist/continence advisor requesting

Please provide supporting documentation from medical specialist/continence advisor ☐ **Yes** ☐ **No**

| | |
|---|---|
| **i) Equipment Factors**<br>• Person/carer is aware that there are supply allocations through EnableNSW and how they can purchase additional supplies if required.<br>• Person/carer has received instructions on use and care of equipment/products<br>• Person/carer has details of local contact for ongoing clinical management if being discharged to another area.<br>If yes, please provide name and contact details of local contact | ☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No ☐ N/A |

**j) Is the person/carer aware of and in agreement with this equipment request?**

☐ Yes Date agreement received: **Equipment request sent** ☐ Yes ☐ No

☐ No N.B. Application will only be processed with consumer/carer agreement.

**4. PRESCRIBER DECLARATION** (tick all that apply)

☐ I confirm that the person/carer is in agreement with this request
☐ A copy of the request has been provided to the person/carer
☐ I understand that all the information I have supplied is true and correct to the best of my knowledge at the time of the assessment
☐ I declare that I have assessed the person and have been granted Out-of-Scope Prescriber status for this equipment and category

☐ I have assessed the person and have the required qualification and level of experience to prescribe this equipment as per the Continence Clinical Criteria **OR**

☐ I have assessed the person and I have been supervised by an eligible prescriber and they have agreed to be nominated as my supervisor for this request

☐ I have read and understood my responsibilities and obligations as provided in the declaration above

| | |
|---|---|
| *Prescriber name* | *If applicable Supervisor's name* |
| *Qualification* | *Qualification* |
| *AHPRA Registration Number* | *AHPRA Registration Number* |
| *Phone* | *Phone* |
| *Email* | *Email* |
| *Name of Service* | *Name of Service* |
| *Days/hours available* | *Days/hours available* |

**NB: Incomplete forms will delay processing of application. Please ensure all contact details are provided.**