Stock Equipment Request Form

☐ New Request	☐ Amended Request	☐ SEED	☐ NDIS Number

PERSONAL INFORMATION

Title	Last name	First name	Date of birth
Address		Suburb	Postcode
Phone		Mobile	
Alternative contact person		Relationship	Contact details
Primary Diagnosis (relevant to this request)		Other medical/health (relevant to this request)	Person's Weight

STOCK ITEMS REQUESTED

Part number	Equipment Name	Replacement	Pick up old item
		Choose	Choose
		Choose	Choose
		Choose	Choose
		Choose	Choose
		Choose	Choose
		Choose	Choose
		Choose	Choose
		Choose	Choose

Is person's weight within the safe working load (SWL) of this equipment? Choose

Is foam surround required? Choose

GOALS

To improve safety and/or independence for person and/or carer with:

☐ Self-care tasks ☐ Transfers ☐ Pressure Management ☐ Ambulant Mobility ☐ Seated Mobility

PERSON'S CURRENT FUNCTIONAL STATUS

Indoor ambulant mobility Choose **Distance (metres)**	**Outdoor ambulant mobility** Choose **Distance (metres)**
Seated mobility Choose **Type** Choose	**Postural Support** Choose
Transfers Choose	**Bathing and Toileting** Choose

PRESSURE MANAGEMENT *(Pressure cushion, static air or alternating air mattresses request)*

Pressure Risk Assessment Tool used: Choose Score/Risk level	Is there a current pressure injury or history of pressure injuries? Choose If Yes: *Stage: *Location: *Duration Have pressure management strategies been implemented? Choose
Bed Mobility Choose	**Ability to re-position in sitting** Choose

ADDITIONAL INFORMATION

Provide any other relevant information regarding the person's current situation or functional status, including risks to carers

EQUIPMENT JUSTIFICATION (complete all relevant sections)

High level mattress (refer to ratings via EnableNSW website)
Describe how the features of the requested mattress will meet pressure care needs

King single bed
If the person is less than 90kg provide reasons why a single bed does not meet the person's clinical needs

Hoist
The hoist is being used for the majority of transfers Choose

POWER MOBILITY GOAL

State the goal for the powered mobility device (Please refer to the relevant funding criteria)

POWER WHEELCHAIR

List and state the need for any additional power features

Seating Specification	**Supplier**
Proposed backrest	Select from approved list to provide seating, delivery and set up
Proposed cushion	Preferred Supplier
Seat Width	
Seat depth	**NB: When the supplier has sent you the seating quote, please forward to: HSNSW-enableeap@health.nsw.gov.au**
Leg-rest type Choose	

SCOOTER (submission of a Medical Questionnaire is mandatory)

The attached medical questionnaire supports the person's ability to safely use a scooter? Choose
Has the person lost their driver's licence due to visual or medical reasons? Choose
Has the person had car accidents or near misses when driving? Choose
Is the person aware they are unable to sit on scooter whilst traveling on public transport? Choose
Is there secure undercover storage available at the person's home? Choose
Has a scooter been used previously? Choose
Does the person understand that the scooter is not to be used as a vehicle? Choose

Provide any other relevant details that may impact on a safe scooter use

COMPATIBILITY

Is the recommended equipment compatible with the:

Current equipment being used Choose Person's transport Choose Environment of Use Choose

DELIVERY INFORMATION ****All prescribers are notified via email of delivery date****

NB: For all scooters and power wheelchairs, the prescriber must be present at delivery	**Delivery address for equipment:** Choose
	If "Other", give details:
For all other equipment, please identify who needs to be contacted to arrange delivery: Choose	**Special delivery instructions (including WHS risks)**
a. A follow up visit will occur after delivery Choose	
b. Prescriber needs to be present at delivery** Choose	
**delivery may be delayed due to supplier and prescriber availability	

Has the person's discharge date (Hospital or TACP) been confimed? Choose

If Yes, Discharge date: If No, please provide details

Discharge destination: ☐ Home ☐ Other, please specify

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
☐ I understand that all information I have supplied 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 **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 **OR**
☐ I have been approved to prescribe Group 1 equipment by my clinical service

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

Prescriber name	***If applicable:* Supervisor 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**

Date submitted

Save and attach this SERF to the online ordering system **Email: HSNSW-enableEAP@health.nsw.gov.au**