EnableNSW
Sleep Positioning Equipment Request Form

When to use this form
Use this form if you cannot submit this request using EnableNSW Online.

Find out more at www.enable.health.nsw.gov.au/online

Filling in this form
You can complete this form on your computer or print and sign it. If you need to print this form ensure you:

- Use blue or black pen
- Print in BLOCK LETTERS
- Sign the prescriber declaration

If you need to request multiple items, from different equipment categories, ensure you submit the request forms together

Eligibility
An EnableNSW application form is required to assess a person's eligibility. A new application form is required every two years **OR** if the person's circumstances change. Application forms can be accessed online at www.enable.health.nsw.gov.au/for_individuals/applying-to-EnableNSW. If we do not have an application form at the time of reviewing this request, the request may go on hold and delay the outcome.

Important information before making this request
- You must be an eligible prescriber for this type of equipment **AND**,
- the equipment requested must meet the applicable funding criteria. You can read more about this at www.enable.health.nsw.gov.au/prescribers/forms
- You must include a quote for all items in this request

For more information
Go to our website www.enable.health.nsw.gov.au or call us on 1800 Enable (1800 362 253)

Privacy
We collect your personal information and the health information of patients to allow EnableNSW to manage and provide its services. This allows us to:

- Assess your eligibility to prescribe assistive technology in accordance with the relevant funding criteria
- Contact you if more clinical information is required about the request, as well as provide status updates about the request
- Share contact details with a supplier if additional support is required for set up of equipment when necessary.

If you would like to view or make changes to your information, please send an email to enable@health.nsw.gov.au or call 1800 Enable (1800 362 253).

A. Request type

☐ New request ☐ Amendment to existing request

Are there other/additional equipment request forms being submitted for this person?

☐ No – the person does not require any additional items and no other requests are being submitted

☐ Yes – the person requires additional items and I will be completing the relevant forms for those items

Date of assessment/review for this equipment D D/M M/Y Y Y Y

B. Person information

1. Person details

Title _____ First name _____ Surname _____

Date of birth D D/M M/Y Y Y Y

Medicare card number ☐☐☐☐ ☐☐☐☐☐ ☐ Ref no. ☐

Person's address _____

_____ State _____ Postcode _____

2. Delivery details

Where will the equipment be delivered to? *Please select one only*

☐ Person's address

☐ Other, please specify where the equipment will be delivered

Contact name

Contact phone number ( )

Delivery address
(if not person's address)

State Postcode

If applicable, confirm the person's hospital or TCP discharge date D D/M M/Y Y Y Y

If applicable, provide any special delivery instructions

C. Diagnosis

3. What is the primary diagnosis in relation to the requested equipment?

4. Provide other relevant diagnosis/co-morbidities

D. Weight

5. Provide the person's weight in kilograms (kgs):

E. Equipment category

6. What equipment are you requesting? *Select item requested*

☐ Sleep positioning equipment

F. Equipment recommendation

7. For replacement requests complete the following: *Select ONE option*

☐ N/A – This equipment has not previously been funded by EnableNSW

☐ Current prescription is no longer clinically appropriate

☐ Current equipment is beyond repair and unsafe to use

☐ Current equipment is due for replacement due to general wear and tear

8. Provide brand/model, supplier details, price and an itemised quote for the requested equipment

Equipment – specifications required	Preferred supplier details	Qty	Cost (inc GST & delivery)	Quote number
			$	
			$	
			$	
			$	
			$	

9. For ALL items, confirm compliance with the relevant Australian or International Standards and/or has Therapeutic Goods Administration (TGA) registration (class 1 medical devices): *Select ONE option*

☐ Yes

☐ No

G. Equipment goals

10. Confirm the person requires sleep positioning equipment to: *Select all that apply*

- ☐ Support safe positioning during sleep
- ☐ Support 24-hour positioning
- ☐ Reduce the need for repositioning during the night
- ☐ Other - provide details below

H. Current function

11. How does the person transfer? *Select ONE option*

- ☐ Independently with/without equipment – specify type of transfer equipment below (if applicable)
- ☐ With assistance of a carer with/without equipment – specify type of transfer equipment below (if applicable)
- ☐ With total assistance – specify type of transfer equipment below (if applicable)

12. How does the person mobilise: *Select ONE option*

- ☐ Walks independently with/without equipment – specify type of mobility equipment below (if applicable)
- ☐ Walks with assistance of a carer with/without equipment – specify type of mobility equipment below (if applicable)
- ☐ Independently uses a wheelchair – specify type (manual or power) below
- ☐ Carer assistance to use a wheelchair (attendant propelled) – specify type (manual or power) below
- ☐ Unable to walk / bedbound

I. Equipment justification

13. I have requested a sleep positioning system to: *Select ALL that apply*

- ☐ Decrease the person's risk of aspiration
- ☐ Reduce the need for repositioning during the night by family or carers
- ☐ Reduce pain, increase comfort and improve sleep quality and / or duration
- ☐ Support the person as they spend more time in bed during the day than their age peers – provide details below

14. I have requested a standard, off-the-shelf sleep positioning system: *Select ONE option*

- ☐ Yes ***Go to question 16***
- ☐ No – I have requested a custom-made system

15. Provide additional clinical justification why a standard, off-the-shelf sleep positioning system does not meet the person's specific clinical need

J. Trial outcomes

16. Confirm a trial was completed: *Select ONE option*

Note that equipment in this category must be trialled

- ☐ Yes – provide details of trial outcomes below, include change in need for repositioning frequency, change in pain scores, change to time spent in bed etc during trial of system
- ☐ No – provide information why a trial was not completed below

K. Compatibility

17. Confirm the equipment is compatible with the: *Select all that apply*

- ☐ Current equipment being used
- ☐ Environment of use
- ☐ Person's weight

L. Safe use, care and maintenance

18. Confirm the person and/or family/carer will receive education in the: *Select all that apply*

- ☐ Safe use of the requested equipment
- ☐ Correct care and maintenance of the requested equipment

Go to next page and complete Section M. Prescriber Eligibility and Declaration

M. Prescriber eligibility and declaration

19. Prescriber eligibility

Confirm you have assessed the person and have the qualification and level of experience to prescribe this equipment in line with the relevant EnableNSW Funding Criteria and Professional Criteria for Prescribers.

☐ Yes ***Go to question 20***

☐ No – I do not have the level of experience to prescribe this type of equipment as required by the funding criteria. The assessment of the person and equipment request has been supervised by an eligible EnableNSW prescriber. Provide your supervisor's name and email address

Supervisor's name | Supervisor's email

20. Prescriber declaration

I confirm the following:

- The person/carer agrees with this request
- A copy of this request will be provided to the person/carer
- As a health professional, I cannot also be the equipment supplier for the same request. This may include but is not limited to a personal or professional relationship with or material interest in the supplier or manufacturer of the equipment listed on this request

I declare that:

- I have the qualification and experience to prescribe this equipment or, I have been supervised by an eligible EnableNSW prescriber for this type of equipment
- All information I have supplied on this application is true and correct to the best of my knowledge at the time of assessment.

Prescriber information:

Prescriber name

Place of work

Address

State Postcode

Qualification | AHPRA registration number

Phone number ( ) | Email

Signature | Date D D/M M/Y Y Y Y

21. Other contacts (optional)

Complete this question if you would like to provide details of any other relevant health professionals who will be involved with the management and monitoring of the person's condition

Other contact 1

Name

Place of work

Address

State Postcode

Qualification | AHPRA registration number

Phone number ( ) | Email

Other contact 2

Name

Place of work

Address

State Postcode

Qualification | AHPRA registration number

Phone number ( ) | Email

Submitting this request

Submit this form and any relevant clinical documentation to enable@health.nsw.gov.au, please include the following in your subject line **Equipment type_Person name_Date submitted** *i.e Sleep positioning equipment_John Smith_01.01.2022*