

#### 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](http://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](http://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](http://www.enable.health.nsw.gov.au/prescribers/forms)
- You must include the relevant stock/contract code for the equipment you are requesting
- If you are requesting an item not available through stock/contract you must contact the EnableNSW Clinical Advisor team before submitting the request

#### Equipment selection and trials

Standard stock equipment from the Equipment Allocation Program (EAP) is available **statewide** and does not require a trial, no matter where the person lives in NSW. If an item on the online catalogue has a green 'stock' banner, you can request this item without completing a trial with the person. All stock items will have a SKUID which you can add to section **F. Equipment recommendation**. All other self-care and mobility items that do not have a stock banner will require a trial.

#### For more information

Go to our website [www.enable.health.nsw.gov.au](http://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](mailto:enable@health.nsw.gov.au) or call 1800 Enable (1800 362 253).

#### A. Request type

New request       Amendment to existing request       SEED 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/YYYY

## B. Person information

### 1. Person details

Title  First name  Surname

Date of birth

Medicare card number          Ref no.

Person's address

State  Postcode

### 2. Delivery details

Where will the equipment be delivered to? *Select ONE option*

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

If applicable, provide any special delivery instructions

Is there equipment that needs to be collected? *Select ONE option*

Yes - contact EnableNSW by email or phone to arrange

No

## 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 all items being requested:*

Mobile hoist       Standing hoist       Ceiling hoist       Hoist accessories

Sling/s and belts       Sit to stand transfer aid       Slide board       Leg lifter (powered)

## F. Equipment recommendation

### 7. For replacement requests complete the following: *Select N/A if new request*

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

Current equipment is no longer clinically appropriate

Current equipment is beyond repair and unsafe to use

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

**8. Provide brand/model, supplier details, price for the requested equipment**

You must attach an itemised quote for all non-stock or non-contract items in this request

Note: Other = Non-stock & non-contract equipment

Equipment – specifications required	Equipment type	Stock SKUID/ Contract/ Quote number	Preferred supplier details	Qty	Cost (inc GST & delivery)
	<input type="checkbox"/> Stock <input type="checkbox"/> Contract <input type="checkbox"/> Other				\$
	<input type="checkbox"/> Stock <input type="checkbox"/> Contract <input type="checkbox"/> Other				\$
	<input type="checkbox"/> Stock <input type="checkbox"/> Contract <input type="checkbox"/> Other				\$
	<input type="checkbox"/> Stock <input type="checkbox"/> Contract <input type="checkbox"/> Other				\$
	<input type="checkbox"/> Stock <input type="checkbox"/> Contract <input type="checkbox"/> Other				\$
	<input type="checkbox"/> Stock <input type="checkbox"/> Contract <input type="checkbox"/> Other				\$
	<input type="checkbox"/> Stock <input type="checkbox"/> Contract <input type="checkbox"/> Other				\$

**9. Confirm any requested non-contract equipment complies with the relevant Australian or International Standards and/or has Therapeutic Goods Administration (TGA) registration (class 1 medical devices) Select ONE option**

- N/A – I have selected stock/contract equipment
- Yes
- No

**G. Equipment goals**

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

- Improve safety and/or independence when completing transfers within the home
- Improve safety for the person and their carer when assisting with transfers
- Ensure safe positioning during transfers

**11. Is the requested equipment needed for daily use?**

- Yes
- No - provide details below

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## H. Current function

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12. 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)


13. 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 - mobile hoist with standard yoke attachment

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14. Confirm the person requires a mobile hoist with standard yoke attachment to complete safe and effective transfers: *Select ONE option*

- N/A – I am not requesting a mobile hoist **Go to question 16**
- Yes
- No – I am requesting a mobile hoist with a pivot frame attachment **Go to question 15**

15. Confirm the following for a pivot frame attachment: *Select ONE option*

- N/A – I am not requesting a mobile hoist
- N/A – I am requesting a mobile hoist with standard yoke attachment
- A mobile hoist with a standard yoke attachment has been considered or trialled and the person is unable to be transferred safely using a standard yoke attachment

## J. Equipment justification - standing hoist or sit-to-stand equipment

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16. If requesting standing equipment, can the person safely weight-bear in standing? *Select ONE option*

- N/A – I am not requesting standing equipment
- Yes – provide detail below
- No – provide detail below


## K. Equipment justification – ceiling hoist

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17. Confirm a mobile hoist has been trialled and the following apply: *Select all that apply*

- N/A – I am not requesting a ceiling hoist **Go to question 22**
- The use of a mobile hoist is unsafe, ineffective or poses a risk of injury to the person and/or their carer
- There is insufficient circulation space within the bedroom to use a mobile hoist
- Other – provide details below


**18. Specify ceiling hoist attachment – standard yoke or pivot frame attachment:** *Select ONE option*

- N/A –I am not requesting a ceiling hoist **Go to question 22**
- Standard yoke attachment
- Pivot frame attachment **Go to question 19**

**19. Confirm the following for a pivot frame attachment:** *Select ONE option*

- N/A –I am not requesting a ceiling hoist **Go to question 25**
- N/A -I am requesting a ceiling hoist with standard yoke attachment
- A ceiling hoist with a standard yoke attachment has been considered or trialled and the person is unable to be transferred safely using a standard yoke attachment

**20. If power traverse is being requested, confirm the following:** *Select all that apply*

- N/A –I am not requesting power traverse with the ceiling hoist
- The person is able to independently transfer using the ceiling hoist with power traverse for the majority of transfers
- The person has demonstrated their ability to don/doff sling independently

**21. For all ceiling hoist requests, confirm the following and attach a completed Installation Declaration Form. Upload completed installation declaration before submitting request.** *Select all that apply*

- N/A –I am not requesting a ceiling hoist
- The person/carer understands that the cost of installation including structural changes/supports, are at their own expense
- The person/carer understands that ongoing/maintenance of the fixed components (including tracking attachments, power supply and structural beams), are at their own expense

#### L. Equipment justification – sling/belt

**22.I am requesting a standard sling (e.g. general purpose, care, hygiene, amputee, belt for a sit-to-stand aid, etc):** *Select ONE option*

- N/A –I am not requesting sling/s or belt **Go to question 25**
- Yes –I am requesting a standard sling **Go to question 25**
- No –I am requesting a custom, in-situ or other non-standard sling -**Go to question 23**

**23. Provide clinical justification for a custom, in-situ or other non-standard sling:**


**24.If you are requesting a second sling confirm:** *Select all that apply*

- N/A –I am not requesting a second sling
- Person is incontinent resulting in the need for frequent washing
- Sling cannot be removed safely for showering and toileting
- I am requesting the second sling from stock

#### M. Equipment justification – leg lifter (powered)

**25.Confirm the following for leg lifter - powered:** *Select all that apply*

- N/A -I am not requesting a leg lifter
- Person is ambulant and able to complete standing transfers
- Person or carer is unable to lift legs on/off an adjustable height bed
- Other options such as low cost equipment and changed transfer techniques have been trialled and unsuccessful in the person's home environment -provide details below
- A trial has been completed in the person's home environment and demonstrates safe and independent transfers -provide details below


## N. Equipment justification: non-contract equipment

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If you have not contacted a Clinical Advisor prior to submitting a request for non-contract equipment, there may be a delay in providing an outcome pending further EnableNSW review

**26. Provide additional clinical justification why stock/contract equipment does not meet the person's specific clinical need and how the non-stock / non-contract item is more suitable. Type N/A if you have requested stock or contract equipment**


## O. Trial outcomes

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

Note that contract equipment (not available in stock) and non-contract equipment must be trialled

- N/A – I have selected stock equipment
- Yes – provide details of trial outcomes below
- No – provide information why a trial was not completed below


## P. Compatibility

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

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

## Q. Safe use, care and maintenance

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**30. 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 R. Prescriber eligibility and declaration**

## R. Prescriber eligibility and declaration

### 31. 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 32**
- 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

### 32. 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

### 33. 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](mailto:enable@health.nsw.gov.au), please include the following in your subject line **Equipment type\_Person name\_Date submitted** *i.e Mobile hoist request\_John Smith\_01.01.2022*