EnableNSW

Prosthesis – Interim, primary and replacement 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

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

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

Major repairs – component and socket replacements cannot be requested using this form. Please use the major repair form available on the EnableNSW website

☐ Interim prosthesis ☐ Primary prosthesis ☐ Replacement prosthesis

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. Confirm the Prosthetic Service Provider (PSP) will contact the person/carer for appointments ☐ **Yes**

C. Diagnosis

3. What was the cause of the person's amputation? *Select ONE option*

- ☐ Amputation – Congenital limb deficiency
- ☐ Amputation – Congenital malformation
- ☐ Amputation – Neoplasm / cancer / tumor
- ☐ Amputation – Neurogenic
- ☐ Amputation – Neurologic complications
- ☐ Amputation – Peripheral vascular disease
- ☐ Amputation – Trauma

4. Provide other relevant diagnosis/co-morbidities

D. Equipment category

5. What limb requires a prosthesis? *Select ONE option*

A separate request MUST be completed for each limb/prosthesis

- ☐ Lower limb prosthesis - left
- ☐ Lower limb prosthesis - right
- ☐ Upper limb prosthesis - left
- ☐ Upper limb prosthesis - right

6. Is there additional limb involvement and/or an osseointegration implant? *Select all that apply*

- ☐ N/A - there are no other limbs involved
- ☐ Bilateral amputee
- ☐ Trilateral amputee
- ☐ Quadrilateral amputee
- ☐ Osseointegration implant

7. What is the level of amputation for this specific request? *Select ONE option*

- ☐ Complete trans-metatarsal (partial foot)
- ☐ Chopart
- ☐ Lis Franc
- ☐ Symes
- ☐ Transtibial (below knee)
- ☐ Knee Disarticulation
- ☐ Transfemoral (above knee)
- ☐ Hip Disarticulation
- ☐ Hindquarter
- ☐ Complete trans-metacarpal (partial hand)
- ☐ Wrist disarticulation
- ☐ Transradial (below elbow)
- ☐ Elbow disarticulation
- ☐ Transhumeral (above elbow)
- ☐ Shoulder disarticulation
- ☐ Forequarter
- ☐ Other

8. What was the date of the amputation? D D/M M/Y Y Y Y

MUST be accurate for ALL interim and primary prosthesis requests. May be estimated for other requests if exact date unknown.

9. What is the person's 'K' activity level? Select potential 'K' activity level for interim and primary prosthesis requests

- ☐ N/A - Upper Extremity request
- ☐ K0
- ☐ K1
- ☐ K2
- ☐ K3
- ☐ K4

E. Weight

10. Provide the person's weight in kilograms (kgs)?

11. Indicate if weight was with OR without prosthesis

- ☐ Yes, with prosthesis
- ☐ No, without prosthesis

F. Equipment goals

12. Confirm the person requires the prosthesis to: *Select all that apply*

- ☐ Increase independence in mobility, transfers and/or core activities of daily living in the home and local community
- ☐ Improve safety in mobility, transfers and/or core activities of daily living in the home and local community
- ☐ Provide cosmesis

G. Amputee clinic details

13. Where was the person assessed/reviewed? *Select ONE option*

- ☐ Albury (Lavington)
- ☐ Bankstown-Lidcombe Hospital
- ☐ Bathurst Base Hospital
- ☐ Camden Hospital
- ☐ Children's Hospital at Westmead (CHW)
- ☐ Coffs Harbour Base Hospital
- ☐ Concord Hospital
- ☐ Dubbo (Lourdes Hospital)
- ☐ Gosford Private
- ☐ Hornsby Kuringai Hospital
- ☐ Hunter Valley Private (Shortland) - Outpatient
- ☐ Lady Davidson Private Hospital (Turramurra) - Outpatient
- ☐ Lismore (St Vincents Lismore - Carroll Centre)
- ☐ Liverpool Hospital (Braeside - Outpatient)
- ☐ Mona Vale (satellite of Hornsby)
- ☐ Mount Druitt (satellite of Westmead)
- ☐ Mt Wilga Private Hospital (Hornsby) - Outpatient
- ☐ Murwillumbah (satellite of Lismore)
- ☐ Nepean Hospital (Kingswood)
- ☐ Orange Base Hospital
- ☐ Port Kembla Hospital (Warrawong)
- ☐ Port Macquarie Base Hospital
- ☐ Prince of Wales Hospital
- ☐ Rankin Park Hospital (New Lambton)
- ☐ Royal North Shore Hospital (St Leonards)
- ☐ Royal Prince Alfred Hospital (RPA Camperdown)
- ☐ Shoalhaven Hospital (Nowra)
- ☐ St George Hospital (Kogarah)
- ☐ St Vincent's Sydney (Darlinghurst)
- ☐ Sutherland Hospital (Caringbah)
- ☐ Sydney Children's Hospital
- ☐ Tamworth Base Hospital
- ☐ Wagga Wagga Base Hospital
- ☐ Westmead Hospital
- ☐ Wingham Hospital (Tarree)
- ☐ Woy Woy Hospital
- ☐ Wyong Hospital (Hamlyn Terrace)
- ☐ Private rooms

14. Date of assessment/review: D D/M M/Y Y Y Y

15. For interim prosthesis requests was the amputee a hospital inpatient when the request was raised? *Select ONE option*

- ☐ NA - not an interim request
- ☐ Outpatient
- ☐ Public hospital/rehabilitation unit inpatient
- ☐ Private hospital/rehabilitation unit inpatient

16. What Allied Health (AH) Professionals were in attendance for the assessment/review?

Provide AH profession/s (eg Prosthetist/Physiotherapist/Occupational Therapist) and their name/s

17. Select the nominated Prosthetic Service Provider (PSP): *Select ONE option*

MUST be contracted PSP for ALL interim lower limb prosthesis requests

- ☐ Albury Prosthetic and Orthotic Services (APOS)
- ☐ APC Prosthetics Alexandria
- ☐ APC Prosthetics Central Coast
- ☐ APC Prosthetics Hunter
- ☐ APC Prosthetics Northmead
- ☐ Hunter Prosthetic and Orthotic Services (HPOS)
- ☐ Innovo Prosthetics
- ☐ Momentum Sports & Rehabilitation Services
- ☐ Northern Prosthetics
- ☐ OAPL – Alexandria
- ☐ Southern Prosthetics & Orthotics (SPAO)
- ☐ Southern Prosthetics & Orthotics (SPAO) Nowra
- ☐ Southern Prosthetics & Orthotics (SPAO) Penrith
- ☐ X-tremity Prosthetics & Orthotics

H. Equipment justification

18. Why does the person require a replacement prosthesis. *Provide detail and attach supporting documentation if required.*

- ☐ N/A (for interim or primary prosthesis requests)

19. For ALL requests are any of the following required? *Select all that apply*

- ☐ N/A - I am not requesting any of these items
- ☐ Titanium components for person who has an activity level of K3 or K4 AND a body weight of LESS than 125KG
- ☐ Titanium components for person who has an activity level of K1-K4 AND a body weight of MORE than 125KG
- ☐ Bariatric components
- ☐ Medical Grade Footwear (complete transmetatarsal level up to Symes level only)
- ☐ Second (spare/work) Prosthesis
- ☐ Waterproofing of the requested prosthesis

20. As per funding criteria provide clinical justification why the item/s listed in the previous question meet the person's specific needs

☐ N/A

I. Equipment justification: Non-standard/non-contract components

21. If the request includes non-standard PLS contract C849 and/or non-contract components provide additional clinical justification why standard contract components do not meet the person's specific needs.

☐ N/A

22. If the request includes a microprocessor knee (MPK)/trial indicate which of the following apply

MPKs **WILL NOT** be funded for interim/primary prosthesis requests

- ☐ N/A - I am not requesting a MPK
- ☐ The person has a history of falls in the last 6 months or since the existing prosthesis was provided
- ☐ The person has a need to carry loads bi-manually on a regular basis
- ☐ The person needs to traverse slopes and uneven ground in adverse conditions frequently
- ☐ The person has significant contralateral limb weakness
- ☐ The person has a high upper-limb amputation, or contralateral lower-limb amputation
- ☐ The person understands the impact on knee cosmesis
- ☐ The person understands the requirements for gait training and is able to attend sessions as recommended by the treating physiotherapist

23. If the request includes a high activity foot indicate which of the following apply. *Select all that apply*

- ☐ N/A I am not requesting a High Activity Foot
- ☐ The person needs to traverse slopes and uneven ground in adverse conditions daily/regularly
- ☐ The person has a need to carry heavy loads daily and/or body weight >125kg
- ☐ The person has Activities of Daily Living (ADLs) or occupation that requires frequent high impact activities
- ☐ The person has a long residuum (>50% tibial length or Symes level amputation)
- ☐ The person has documented history of prosthetic foot failure with other feet
- ☐ The person has been funded/approved for a Microprocessor Knee

J. Equipment recommendation/prosthesis design

24. Specify prosthesis requirements. Include socket, suspension, knee/elbow, ankle/wrist, foot/terminal device, consumables, other.

Note PSP must provide code, cost and warranty for all non-contract items in this request

☐ N/A – I have selected contract equipment

Socket	
Suspension	
Knee/Elbow	
Ankle/Wrist	
Foot/Terminal Device	
Consumables	
Other	

25. Confirm the 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 all that apply*

☐ N/A – the prosthetic limb will only include PLS C849 contract components

☐ Yes

K. Safe use, care and maintenance

26. 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 L. Prescriber eligibility and declaration

L. Prescriber eligibility and declaration

27. 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 - I am an accredited EnableNSW Prosthetic Limb Service prescriber

Prescriber number

28. 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 and am an accredited prescriber with EnableNSW.
- 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

Signature

Date D D/M M/Y Y Y Y

29. 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 PLS_John Smith_01.01.2022*