EnableNSW
Manual Wheelchair 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 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 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 ☐ 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/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? *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

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

☐ Yes – contact EnableNSW via email or phone to arrange collection

☐ 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 that apply*

☐ Manual wheelchair (MWC)

☐ Wheelchair accessories

☐ Wheelchair seating (excluding pressure cushion)

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 general wear and tear

8. **List all recommended equipment (including seating and accessories). 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	Preferred supplier details	Qty	Cost (inc GST & delivery)	Stock SKUID/ Contract/ Quote number
	☐ Stock ☐ Contract ☐ Other			$	
	☐ Stock ☐ Contract ☐ Other			$	
	☐ Stock ☐ Contract ☐ Other			$	
	☐ Stock ☐ Contract ☐ Other			$	
	☐ Stock ☐ Contract ☐ Other			$	
	☐ Stock ☐ Contract ☐ Other			$	
	☐ Stock ☐ Contract ☐ Other			$	
	☐ Stock ☐ Contract ☐ 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 manual wheelchair to:** *Select all that apply*

☐ Improve safety and / or independence when mobilising within the home

☐ Improve safety and / or independence when mobilising within the community

☐ Complete core activities of daily living

☐ Be safely assisted by a carer

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)
- ☐ 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

13. Does the person require postural support when sitting? *Select ONE option*

- ☐ Sits independently
- ☐ Sits upright with trunk support
- ☐ Requires tilt to maintain upright trunk and head
- ☐ Has fixed postural deformities

14. Does the person have a current or previous history of pressure injury? *Select ONE option*

- ☐ No
- ☐ Yes - provide additional details including location and stage, relevant to the requested wheelchair, wheelchair configuration and seating below

I. Equipment justification: All requests:

15. I am requesting a standard/off the shelf manual wheelchair (non-tilting or tilting): *Select ONE option*

- ☐ Yes
- ☐ No – I am requesting a Lightweight Customised MWC
- ☐ No – I am requesting an Ultra-lightweight Customised MWC

J. Equipment justification - standard off the shelf tilt-in-space manual wheelchair

16. For all tilt-in-space manual wheelchair requests, confirm: *Select all that apply*

- ☐ N/A – I am not requesting a tilt-in-space MWC - ***Go to question 18***
- ☐ The person requires tilt to assist with pressure management
- ☐ The person requires tilt to support safe positioning for activities of daily living

K. Equipment justification - customised tilt-in-space manual wheelchair

17. If requesting a customised tilt-in-space manual wheelchair, confirm: *Select all that apply*

- ☐ N/A - I am not requesting a customised tilt-in-space MWC
- ☐ A standard off the shelf tilt-in-space MWC has been considered and is not clinically suitable - provide details below
- ☐ The person requires specific seating to accommodate postural needs or body shape, such as fixed postural deformities - provide details below

L. Equipment justification: Lightweight customised manual wheelchair

18. If requesting a lightweight customised manual wheelchair, confirm: *Select all that apply*

- ☐ N/A - I am requesting a standard wheelchair or an Ultra-Lightweight Customised MWC
- ☐ Person is a full-time wheelchair user
- ☐ MWC is able to be used in the home
- ☐ Standard off the shelf MWCs investigated and are not clinically suitable – provide details below

19. Confirm one of the following: *Select ONE option*

- ☐ Person requires a lightweight customised manual wheelchair as they are unable to independently propel a standard manual wheelchair and / or sit independently to complete functional activities
- ☐ Person requires customisation / additional postural support to optimise independent mobility or to complete essential ADLs

M. Equipment justification: Ultra-lightweight customised manual wheelchair

20. If requesting an ultra-lightweight customised manual wheelchair, confirm: *Select all that apply*

- ☐ N/A - I am requesting a standard MWC or a Lightweight Customised MWC
- ☐ Customised MWC trialled and is not clinically suitable – provide details below
- ☐ A trial of the ultra-lightweight MWC showed evidence of improved function in mobilising when compared to using a customised MWC of a similar set up - provide measurable outcomes that demonstrate the need for an ultra-light MWC below

E.g. endurance, distance, speed, maneuverability, and/or activities of daily living that can be completed independently

Type N/A if you are not requesting an ultra-lightweight wheelchair

N. Equipment justification: Wheelchair accessories/modifications/features

21. What features, modifications and upcharges are you requesting for the wheelchair? *Select ONE option*

See funding criteria for list of accessories and features

- ☐ N/A - I am not requesting wheelchair accessories/modifications/features
- ☐ I am requesting standard accessories/modifications/features
- ☐ I am requesting customised accessories/modifications/features (additional cost and/or upcharges) – provide clinical justification below

O. Equipment justification: Wheelchair seating/seating accessories

22. What other seating/seating accessories are you requesting? *Select all that apply*

☐ Backrest ☐ Seating System ☐ Lateral/medial supports ☐ Headrest ☐ Harness

Other

23. Provide clinical reasoning for the backrest if requested: *Type N/A if not applicable*

24. Provide clinical reasoning for the seating system if requested (custom moulded seating or back and cushion systems):

Type N/A if not applicable

25. **Provide clinical reasoning for lateral / medial supports if requested e.g. lateral trunk supports or thigh supports:** *Type N/A if not applicable*

26. **Provide clinical reasoning for the harness if requested:** *Type N/A if not applicable*

27. **Provide clinical reasoning for a specialised headrest that includes anterior/ head and shoulder/neck support:** *Type N/A if not applicable*

28. **Please list and provide clinical reasoning for any other seating or seating accessories requested:** *Type N/A if not applicable*

P. Equipment justification: Non-contract equipment

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

29. **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 requesting stock or contract equipment*

Q. Equipment justification: Non-contract equipment

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

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

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

R. Compatibility

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

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

S. Safe use, care and maintenance

32. **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

33. **Confirm the wheelchair:** *Select all that apply*

- ☐ Will not impact the person's safety
- ☐ Will not restrict their independence or voluntary movement

T. Prescriber eligibility and declaration

34. 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 35***

☐ 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

35. 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

36. 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 Manual wheelchair_request_John Smith_01.01.2022*