EnableNSW

Bathing, Showering and Toileting 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 SKUID/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 discha rge 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 all items being requested:*

Bath seat (paediatric) | Bedside commode | ☐ Mobile shower commode | Mobile shower commode accessories

Bariatric over toilet aid | ☐ Bariatric shower chair | ☐ Bariatric shower stool

Shower trolley | ☐ Transfer bench | Swivel bather

Other toileting/showering/bathing equipment (e.g. bariatric bathboard, bariatric toilet surround, toilet rail attached, RTS with arms, tub buddy/slider) *Specify equipment*

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. 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)
	☐ 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 bathing/showering/toileting equipment to: *Select all that apply*

☐ Achieve safe and/or independent completion of personal care tasks

☐ Be safely assisted by a carer to complete personal care tasks

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

13. Does the person require postural support when sitting: *Select all that apply*

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

I. Equipment justification: tilt-in-space mobile shower commode

14. If requesting a tilt-in-space mobile shower commode, confirm the person requires tilt: *Select all that apply*

- ☐ N/A – I am not requesting a tilt-in-space mobile shower commode
- ☐ To achieve/maintain adequate support for safe showering
- ☐ To facilitate safe hoist transfers
- ☐ For pressure injury risk/management
- ☐ Other – specify

J. Equipment justification: mobile shower commode (MSC) accessories and modifications

15. Are you requesting customised accessories and/or modifications: *Select ONE option*

- ☐ N/A – I am not requesting mobile shower commode accessories and modifications ***Go to question 17***
- ☐ N/A – I am requesting standard mobile shower commode accessories and modifications ***Go to question 17***
- ☐ Yes – ***Go to question 16***

16. Provide the clinical justification for each requested accessory or modification. For example: custom-made seat, frame modification, back/armrest modification:

K. Equipment justification: toileting equipment

17. If requesting toileting equipment, confirm the person:

- ☐ N/A – I am not requesting toileting equipment
- ☐ Cannot safely and effectively transfer on/off toilet without the requested equipment

L. Equipment justification: bedside commode

18. If requesting a bedside commode, confirm the person:

- ☐ N/A – I am not requesting bedside commode
- ☐ Cannot complete safe toileting at night in the bathroom/toilet

M. Equipment justification: shower and/or bath equipment

19. If requesting equipment for showering or bathing, confirm the person: *Select all that apply*

- ☐ N/A – I am not requesting showering and/or bathing equipment
- ☐ Cannot safely and effectively stand to shower
- ☐ Cannot safely and effectively transfer into a shower over the bath or into a bath

N. Equipment justification: other equipment

20. For bath lift requests confirm all of the following:

- ☐ N/A - I am not requesting a bath lift
- ☐ Standard bathing and toileting equipment has been considered and/or trialled and is not clinically suitable
- ☐ Long term transfer needs and potential risk to carer have been considered
- ☐ Home visit and successful trial has been completed

21. For hybrid or multi-purpose equipment for bath/shower/toilet (e.g. tub buddy/slider) confirm the following:

- ☐ N/A - I am not requesting a hybrid/multipurpose equipment
- ☐ Standard bathing and toileting equipment has been considered and/or trialled and is not clinically suitable
- ☐ Home visit and successful trial has been completed

22. For hydraulic shower trolley confirm all of the following:

- ☐ N/A - I am not requesting a shower trolley
- ☐ Bathing or showering is not possible in a tilt-in-space mobile shower commode (MSC)
- ☐ Home visit has been conducted toconfirm there is sufficient space in the bathroom to accommodate the shower trolley, other equipment and the carer

O. 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

23. 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*

P. Trial outcomes

24. 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

Q. Compatibility

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

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

R. 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 S. Prescriber eligibility and declaration

S. 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 ***Go to question 28***

☐ 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

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 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

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 Bathing request_John Smith_01.01.2022*