EnableNSW
Beds and Mattresses 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 **E. Equipment category**. 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

3. Confirm a one-piece (non-folding) bed can be delivered into the person's home: *Select ONE option*

☐ N/A

☐ Yes

4. Is there equipment that needs to be collected: *Select ONE option*

☐ Yes – contact EnableNSW by email or phone to arrange

☐ No

C. Diagnosis

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

6. Provide other relevant diagnosis/co-morbidities

D. Weight

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

E. Equipment category

8. What equipment are you requesting? *Select all items being requested*

☐ Adjustable bed ☐ Bed accessories ☐ Bed rail ☐ Self-help pole

☐ Power air mattress ☐ Static air/hybrid mattress ☐ Foam mattress ☐ Mattress accessories

F. Equipment recommendation

9. 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

10. 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				$

11. 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

12. Confirm the person requires bed/mattress/accessories equipment to: *Select all that apply*

- ☐ Assist in managing an existing pressure injury
- ☐ Reduce the risk of developing a pressure injury
- ☐ Support safe and/or independent transfers
- ☐ Achieve appropriate positioning using the adjustable bed features
- ☐ Reduce the risk of injury to carers

H. Current function

13. 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)

14. 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: bed

15. Are you requesting a standard single (pull-apart) bed: *Select ONE option*

- ☐ N/A – I am requesting a mattress only - ***Go to question 18***
- ☐ Yes – I am requesting a standard single (pull-apart) bed - ***Go to question 18***
- ☐ No – I am requesting a specialist bed

16. If requesting a one-piece bed, provide details of trial of a standard pull-apart bed and reasons why this is not clinically suitable *Type N/A if not requesting a one-piece bed*

17. If requesting an extra low bed, confirm: *Select all that apply*

- ☐ N/A – I am not requesting an extra low bed
- ☐ Extra low height is essential for independent transfers and variable height is required for provision of care
- ☐ Documented safety issues cannot be solved through other measures - provide details below
- ☐ Person has a documented recent history of falls from bed - provide details below

18. If requesting a king single (pull-apart/one-piece / extra low) bed, confirm the person: *Select all that apply*

- ☐ N/A – I am not requesting a king single bed
- ☐ Weighs more than 90 kg
- ☐ Requires a king single bed because their size or postural configuration requires a wider bed - provide details below
- ☐ Requires a king single bed because their repositioning technique or transfers, requires a wider bed - provide details below

19. If requesting a bariatric super king single bed (stock), confirm the person: *Select all that apply*

- ☐ N/A – I am not requesting a bariatric super king single bed (stock)
- ☐ Weighs more than 260kg
- ☐ Weighs more than 170kgs and a contract bariatric one-piece bed cannot be delivered due to environmental restrictions

20. What bed and mattress accessories are required: *Select all that apply*

- ☐ N/A – I am not requesting accessories
- ☐ Full-length rails ☐ ¾ length rails ☐ Clamp on rail/s ☐ Self-help pole ☐ Bed extension & bolster
- ☐ Foam surround ☐ 50mm foam mattress underlay for use with a power mattress overlay

J. Equipment justification: mattress

21. Does the person have an existing pressure injury or are they at high risk of developing a pressure injury?

- ☐ No
- ☐ Yes – provide detail including pressure injury risk rating, history of pressure injury and/or location and stage of any existing pressure injuries below

22. Are you requesting a standard foam mattress?

- ☐ Yes – ***go to question 26***
- ☐ No – ***go to question 23***

23. For group A mattress (including power mattress overlays and replacement systems and, nonpower air & foam mattresses and static air mattress sections): *Select all that apply*

- ☐ N/A – I am not requesting a group A mattress
- ☐ Person has a stage 1-2 pressure injury or person is identified as 'at risk' of sustaining a pressure injury as documented on a validated risk assessment tool
- ☐ The mattress is appropriate for long term prevention or management of a pressure injury

24. For group B mattress (including power mattress overlays and replacement systems), select all that apply:

- ☐ N/A – I am not requesting a group B mattress
- ☐ Person has a previous or current pressure injury (any stage)
- ☐ Person is identified as having a 'high risk' or 'very high risk' of sustaining a pressure injury as documented on a validated risk assessment tool
- ☐ The mattress is appropriate for long term prevention or management of a pressure injury

25. For group C mattress (including Power mattress overlays and replacement systems), select all that apply:

- ☐ N/A – I am not requesting a group C mattress
- ☐ Person has a previous or current stage 3-4 pressure injury; or an unstageable or deep tissue pressure injury
- ☐ Person identified as 'very high risk' on a validated risk assessment tool
- ☐ The mattress is appropriate for long term prevention or management of a pressure injury

K. 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

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 requesting stock or contract equipment*

L. Trial outcomes

27. 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

M. Compatibility

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

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

N. Safe use, care and maintenance

29. 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

30. Confirm the bed, rails, accessories or mattress: *Select all that apply*

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

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

O. 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 D D/M M/Y Y Y Y

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, please include the following in your subject line **Equipment type_Person name_Date submitted** *i.e Bed and mattress request_John Smith_01.01.2022*