EnableNSW

Transfer Equipment Vehicle 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 attach a quote to this form for the equipment you are requesting

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

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 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:*

☐ Portable ramp - vehicle ☐ Vehicle hoist - person ☐ Vehicle hoist – wheelchair

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. **List recommended equipment. 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

Equipment – specifications required	Equipment type	Contract/ Quote number	Preferred supplier details	Qty	Cost (inc GST & delivery)
	☐ Contract ☐ Other				$
	☐ Contract ☐ Other				$
	☐ 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 vehicle transfer equipment to:** *Select all that apply*

☐ Improve safety and/or independence when completing transfers to/from the vehicle

☐ Improve safety for the person and their carer when assisting with vehicle transfers

☐ Complete regularly occurring community based activities/core daily 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

I. Equipment justification: portable ramp for a vehicle

13. **For a portable ramp for a vehicle, confirm the following:** *Select all that apply*

☐ N/A – I am not requesting a portable ramp

☐ The person or carer is unable to lift the unoccupied wheelchair into the vehicle

☐ Will be used to load the unoccupied wheelchair into a vehicle that is owned by the person or family

☐ Person can be safely transferred into/out of the car seat, prior to the carer loading the wheelchair

☐ The carer is able to apply/remove and stow the ramp

J. Equipment justification: vehicle hoist - person

14. Confirm the vehicle hoist (person): *Select all that apply*

- ☐ N/A – I am not requesting a vehicle hoist (person)
- ☐ Is for a person who is unable to stand, step or slide into the vehicle, with or without assistance
- ☐ Can be operated by a carer
- ☐ Is for use on a vehicle that is owned by the person or family
- ☐ Can be installed on the person's/family's vehicle

K. Equipment justification: vehicle hoist - wheelchair

15. Confirm the vehicle hoist (wheelchair): *Select all that apply*

- ☐ N/A – I am not requesting a vehicle hoist (wheelchair)
- ☐ Is for the wheelchair user who is an independent driver and can transfer into/out of the vehicle seat independently
- ☐ Can be operated by the person independently
- ☐ Is for use on a vehicle that is owned by the person or family
- ☐ Can be installed on the person's/family's vehicle

L. Equipment justification – installation of vehicle hoist (person or wheelchair)

16. Confirm the following and attach a completed Installation Declaration Form for a vehicle hoist (person or wheelchair)
Select ONE only

- ☐ N/A – I am requesting a portable ramp
- ☐ Person/family understands that the cost of installation is at their own expense

M. Trial outcomes

17. Confirm a trial demonstrated safe and effective use of the equipment:

- ☐ Yes - provide details of trial outcome below, including duration and location
- ☐ No - provide information why a trial was not completed below

N. Compatibility

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

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

O. Safe use, care and maintenance

19. 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 P. Prescriber eligibility and declaration

P. Prescriber eligibility and declaration

20. 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 21***

☐ 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 _____

21. 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

22. 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 Transfer equipment_request_John Smith_01.01.2022*