

# EQUIPMENT PRESCRIPTION FORM



The information in this form is for use by the organisation which has requested it and will not otherwise be exchanged with any other party, except in accordance with law. Please see section 15 of this form for privacy information.

## IMPORTANT

- Please type or use block letters and **ensure that all sections are complete**. All incomplete forms will be returned, so please give reasons if you are unable to complete a section
- Where there is insufficient space, please attach further information to the back of this form.

This form must be completed for all requests for the following equipment

▪ Wheelchairs	▪ Recumbent trikes (TAC only)	▪ Large exercise equipment (TAC only)
▪ Pressure cushions	▪ Beds	▪ Lounge chairs / tilt recliners
▪ Powered conversion kits	▪ Mattresses	▪ Custom toilet / shower / commode chairs
▪ Hoists	▪ Standing frames	▪ Shower trolleys
▪ Scooters	▪ Tilt tables	▪ Mainstream multifunctional technology (i.e. tablets, smartphones, computers. etc.)
▪ Bikes (TAC only)	▪ Treatment couches	▪ Ramps
▪ Any other single item that exceeds \$1,500.00.		

This form must also be completed for repairs or modifications to existing equipment in the above list.

You need to contact the TAC/WorkSafe Equipment Contractors to conduct trials of equipment.

## TAC/WorkSafe Equipment Contractors are:

### Independence Australia

Phone 1300 788 855  
Fax 1300 788 811  
www.independenceaustralia.com.au

### Aidacare

Phone 9981 2100  
Fax 9386 9170  
www.aidacare.com.au

### Endeavour Life Care

Phone 9703 2900  
Fax 9702 3465  
www.endeavourlifecare.com.au

### GMS Rehabilitation

Phone 1300 734 223  
Fax 1300 734 553  
www.gmsrehab.com.au

## 1. Your details

Contracted	Non-Contracted
<input type="checkbox"/> Benefit and Support Services Assessor BASSA <b>NOTE:</b> You must only complete Section 12 if you are requesting follow-up services	<input type="checkbox"/> Community Occupational Therapist <b>NOTE:</b> You do not need to complete Section 12
<input type="checkbox"/> Network Occupational Therapist <b>NOTE:</b> You do not need to complete Section 12	<input type="checkbox"/> Other health professional, e.g. physiotherapist <b>NOTE:</b> You do not need to complete Section 12

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### 2. Client/Worker details

Client/Worker name

Type of claim

TAC ☐

WorkSafe ☐

Agent:

Client/Worker address

Postcode

Claim number

Telephone number

Date of Birth

Date of injury

Employer (WorkSafe clients  
only)

Employer telephone number  
(WorkSafe clients only)

Current occupation (WorkSafe  
clients only)

Pre-injury occupation

Date of assessment

Date report submitted

Delivery contact person

Delivery contact telephone number

Delivery address and instructions

### 3. Current level of function

Transport accident/Work-related injuries and relevant medical history. *Consider cognitive function/behaviour and prognosis*

Social situation. *Consider where the client/worker lives, who he/she lives with, any other formal or informal supports, and if there are any plans for change in the future*

Specific functional limitations. *Consider height, weight, upper and lower limb function, posture, balance, cognitive, communication, behavioural or emotional issues resulting from the transport accident or work-related injury*

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Current functional status. *Include a general overview of the client/Worker's level of function in the following areas: transfers, mobility, pressure management, personal care, domestic tasks, community access and work/recreation/leisure. Include details specifically relevant to the equipment being prescribed*

### 4. Clinical justification

Purpose of recommended equipment. *Consider intended ADLs, social and intended use (indoors, outdoors and frequency)*

Expected measurable outcomes. *Please be specific about how the equipment will maximise functional independence and/or support clinical goals*

### 5. Discussion with treating healthcare professionals

Provide the outcomes of the discussions you have had with the client/worker's other treating healthcare professionals about your recommendations. *Include any differences in opinion or support for your recommendations*

### 6. Trials

Did you make your recommendation after trialling products from the *Equipment List*? ☐ Yes ☐ No

If 'no', please provide clinical reasoning to support why the *Equipment List* products did not meet the client/worker's needs

Please note that the trialling of products from the *Equipment List* and/or Equipment Contractors is mandatory. Failure to do so without clinical justification will result in the *Equipment Prescription Form* being returned.

#### Details of the trial

Equipment. <i>Include all equipment trialled, including the equipment you recommend in section 7</i>	Length and location of trial. <i>Include equipment provider name</i>	Outcomes and client/carer feedback. <i>Include justification for the equipment you recommend in section 7</i>

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### 7. Details of recommended equipment

Details of recommended equipment, including model and specifications

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Are non-standard options or non-standard customisations required? Yes ☐ No ☐

If 'yes', please specify feature, function and clinical justification for non-standard options and customisations

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Have you considered day-to-day transportation of the equipment? ☐ Yes ☐ No ☐ Not applicable

Have you considered the compatibility with existing equipment and the client/worker's environment? ☐ Yes ☐ No

Have you considered the safety of the client/worker and carers with this equipment? ☐ Yes ☐ No

Has there been multidisciplinary team consensus? ☐ Yes ☐ No

Is this equipment available from the Equipment Contractors? \* ☐ Yes ☐ No

\*If 'no', the Claims Manager will refer the order to the Equipment Brokerage Team

Additional comments. *Please provide more information where the answer to any of the above is 'no'*

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### Method of equipment provision

☐ Purchase

☐ Hire

If hire, for how long?

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\* Please consider purchase of equipment if hire is for an extended period of time and the hire cost will exceed the cost to purchase the item.

### Type of supply

☐ Initial provision

☐ Replacement

☐ Modification

If equipment is being replaced or modified, please specify the following

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Type and model of current equipment

Date purchased

 / 

Limitation of current equipment

Reasons for replacement

### 8. Quotation

*Only required for customised items and items that do not appear on the Equipment List*

Has the selected Equipment Contractor provided a written quotation?

☐ Yes

☐ No

If 'no', explain why the equipment is not available through the Equipment Contractors

### 9. Anticipated maintenance

Consider warranty and supplier's recommended service schedule. For example, requires annual mechanical servicing, etc.

### 10. Are there any training requirements?

☐ Yes ☐ No

*If 'yes', outline anticipated training requirements for the client/worker and/or carers*

### 11. Will you conduct a review of the equipment after delivery?

☐ Yes ☐ No

If 'no', please explain why a review is not required

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### 12. Benefit and Support Services Assessor only

#### Prescribing occupational therapist follow-up services

The TAC/WorkSafe Agent is able to approve a maximum of 6 hours to provide follow-up services.

Explain why follow-up services or training are recommended	Frequency and duration of follow-up services, e.g. <i>Weekly follow-up for 2 months</i>	Comments, <i>including additional travel time</i>

#### Is a referral for further occupational therapy services required?

☐ Yes ☐ No

Referral is required if follow-up is anticipated to be greater than 6 hours. If 'yes', please outline the areas that need to be addressed

### 13. Additional comments

### 14. Prescribing Occupational Therapist or health professional details

I have discussed the information contained in the *Equipment Prescription Form* with the client/worker or carers and other members of the treating team, including the requested equipment, the aims, predicted outcomes, maintenance and training requirements.

Provider name, address and phone no. *Use practice stamp where possible*

Signature

Days/hours available

Date

### 15. Personal and health information

#### TAC

The TAC will retain the information provided and may use or disclose it to make further inquiries or assist in the ongoing management of the claim or any claim for common law damages. The TAC may also be required by law to disclose this information. Without this information the TAC may be unable to determine entitlements or assess whether treatment is reasonable and may not be able to approve further benefits and treatment

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### WorkSafe

Personal and health information collected by WorkSafe on this form is used for the purpose of processing, assessing and managing claims under the *Accident Compensation Act 1985* (the Act). It may also be used for other related purposes including legal proceedings arising under the Act, to assist with a worker's rehabilitation and return to work and to assist WorkSafe and its Agents to better manage claims generally.

For the purposes of processing, assessing and managing a claim, WorkSafe and the Agent of the injured worker's employer may disclose personal and health information about the worker to each other and to the following types of organisations:

- employees, contractors and agents of WorkSafe and WorkSafe Agents;
- employers of the injured worker;
- solicitors, medical practitioners and other health service providers, private investigators, loss adjusters and other service providers acting on behalf of WorkSafe or the Agent in relation to the claim;
- the Accident Compensation Conciliation Service and Medical Panels;
- a court or tribunal in the course of criminal proceedings or any proceedings under any of the Acts which WorkSafe administers;
- any other person, organisation or government agency authorised by you, or by law, to obtain the information.

An individual may request access to personal and health information about them collected by WorkSafe or an Agent by contacting the Agent.

WorkSafe's Privacy Policy is available at the nearest WorkSafe office or at [www.worksafe.vic.gov.au](http://www.worksafe.vic.gov.au).