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| --- | --- | --- | --- | --- | --- |
| New Request  Amendment to existing request  Replacement request  Type of Equipment requested  Orthoses  Medical Grade Footwear | | | | | |
| 1. PERSON INFORMATION | | | | | |
| **First Name** enter text.  **Last Name** enter text.  **Title** Choose an item or enter text  **Date of birth:** enter text. | | **Address** enter text.  **Suburb & Post Code** enter text.  **Phone** enter text.  **Mobile** enter text. | | | |
| **Contact person** (if not client) **and relationship to client**  enter text. | | **Contact Person contact details**  enter text. | | | |
| 1. **Presenting diagnosis requiring support or correction** (if known, include date of injury/diagnosis or onset)   enter text. | | **Co-morbidities**  enter text. | | | |
| **(b) What body location requires an orthosis (select all that apply)?**  Lower Limb Right Lower Limb Left Upper Limb Right Upper Limb Left Spine/torso  Other: enter text. | | | | | |
| **2. IDENTIFICATION OF NEED** | | | | | |
| **(a) Provide the clinical reasoning and describe the structural and/or functional characteristics for why this person requires footwear/orthoses- attach any relevant supporting documentation such as foot measurements or tracings, photos, other reports:**  enter text.  **(b) Goal of orthoses and/or Footwear provision (select all that apply):**  Increased independence in mobility, transfers and/or core activities of daily living in the home and local community  Improved safety in mobility, transfers and/or core activities of daily living in the home and local community  Prevent ulceration and/or reduce symptoms associated with the person’s condition  Other: enter text. | | | | | |
| **(c) How often will the orthosis/footwear be used?**  Continually or multiple times each day  1x daily  1 – 2 x weekly  Additional Comment: enter text. | | | | | |
| **3. ORTHOSES / FOOTWEAR JUSTIFICATION** | | | | | |
| **(a) Date of assessment or review:** enter date  **(b) Is the person at risk of falls and/or injury without the requested orthoses/footwear?**  YES  NO  If YES, please describe: enter text.  **(c) Is the person at risk of ulceration or is there a pre-ulcerative pressure lesion?**  YES  NO  **(d) If you are requesting a replacement item please select from the following:**  Current prescription is no longer clinically appropriate  Current Orthoses/Footwear are beyond repair and unsafe for use  Current Orthoses/Footwear are due for replacement due to general wear and tear | | | | | |
| **PLEASE COMPLETE ALL RELEVANT QUESTIONS** | | | | | |
| **ORTHOSES**  What other cost effective orthotic options have been considered and why these are not appropriate?  enter text. | | | | | |
| **MEDICAL GRADE FOOTWEAR – MUST be completed for ALL Footwear requests**  Have you considered prefabricated Medical Grade Footwear?  YES  NO  Please provide clinical justification if prefabricated Medical Grade Footwear options are not appropriate?  enter text.  **Please select which category of Footwear the request meets:**  **Category 1**  **Does the person have an abnormal foot shape/deformity that is unable to fit into regular footwear?**  YES  NO  If YES, please describe: enter text.  **PLUS at least one of the following (select all that apply)**  Increased risk of amputation as a result of peripheral neuropathy (failed 10g monofilament) and/or ischaemia (e.g. impalpable pulses, ABI<0.8, or vascular study) plus deformity and/or previous foot ulceration  Chronic oedema resulting in inability to fit into regular footwear, despite being under medical/professional management  Severe limitations in ability to perform activities of daily living  Please provide detail: enter text.  **Category 2**  **Does the person require footwear to accommodate orthoses?**  YES  NO  If YES, please confirm all of the following:  Person has requested, or is currently using, custom lower limb orthoses that meet the EnableNSW funding criteria  Person has a need for an extra depth or extra width that cannot be accommodated in regular footwear, including through purchase of split sizes  Person has a history of, or is at risk of, serious injury as a result of being unable to wear orthoses due to inappropriate footwear  **Category 3**  **Does the person’s Footwear require modifications that are beyond what is achievable with regular footwear?**  YES  NO  If YES, please describe the modifications required and provide clinical justification: enter text.  **Category 4**  **Is the footwear requested as an alternative to Ankle Foot Orthoses?**  YES  NO  If YES, please provide clinical justification: enter text. | | | | | |
| 4. ORTHOSES AND/OR FOOTWEAR RECOMMENDATION | | | | | |
| **Provide details of orthoses and/or footwear specifications plus written quotes from supplier.** | | | | | |
| **Equipment –specifications required** | **Preferred supplier details** | | **Qty** | **Cost (inc GST & Del)** | **Quote number** |
| **1.** enter text. | enter text. | | Choose an item. | **$** enter | enter |
| **2.** enter text. | enter text. | | Choose an item. | **$** enter | enter |
| **3.** enter text. | enter text. | | Choose an item. | **$** enter | enter |
| **4.** enter text. | enter text. | | Choose an item. | **$** enter | enter |
| 5. TRIAL OUTCOMES | | | | | |
| **Please complete the following sections for all orthotic and/or footwear requests** | | | | | |
| **Has the person used this equipment before and has it achieved the goals identified?**  YES, achieved goals  YES, did not achieve goals  NO, not used before  If YES, please comment on the outcomes:  enter text.  **Is the person/carer(s) capable of using the recommended equipment safely and appropriately?**  YES  NO | | | | | |
| 6. DELIVERY INFORMATION | | | | | |
| **Supplier/prescriber to contact person for an appointment** | | | | | |
| 7. PRESCRIBER DECLARATION | | | | | |
| **DECLARATION**  I declare that I have assessed the person and have the required qualification and level of experience to prescribe this equipment according to the Professional Criteria for Prescribers  **OR**  I declare that I have assessed the person and have been supervised by enter text.  who is an eligible prescriber and has agreed to be nominated as my supervisor for this prescription  **AND**  I confirm that the person / carer is in agreement with this request  I confirm a copy of this request will be provided to the person / carer  I confirm that all information I have supplied on this application is true and correct, to the best of my knowledge at the time of assessment  I have read and understand my responsibilities and obligations as provided in the declaration above. | | | | | |
| **Prescriber name:** enter  **Qualification:** enter  **AHPRA Registration # if applicable:** enter  **Phone:** enter  **Email:** enter  **Name of service:** enter  **Days/Hours available:** enter  **Signature:** enter  **Date:** enter date | | **Supervisor name (if applicable):** enter  **Qualification:** enter  **AHPRA Registration # if applicable:** enter  **Phone:** enter  **Email:** enter  **Name of service:** enter  **Days/Hours available:** enter  **Signature:** enter  **Date:** enter date | | | |

**NB: Incomplete forms will be sent back. Please ensure all contact details are provided.**