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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 [ ]  NOIf 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 [ ]  NOPlease 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 [ ]  NOIf 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 livingPlease provide detail: enter text.**Category 2****Does the person require footwear to accommodate orthoses?**[ ]  YES [ ]  NOIf 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 [ ]  NOIf 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 [ ]  NOIf 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 beforeIf 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.**