**General information and instructions**

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

|  |  |  |
| --- | --- | --- |
| * Wheelchairs
 | * Customised chairs
 | * Mattresses
 |
| * Recliner chairs
 | * MMT
 | * Standing frames
 |
| * Pressure cushions
 | * Scooters
 | * Tilt tables
 |
| * Hoists
 | * Beds
 |  |

This form must also be completed for repairs or modifications to these existing equipment items if the repairs exceed $1000.

It is expected that prescribing therapists conduct trials of items from the Equipment List (if available) with WorkSafe Equipment contracted suppliers before recommending any non-contracted items from an alternative supplier. Details of the WorkSafe Equipment Contracted Suppliers are available from **https:/**[**/www.worksafe.vic.gov.au/equipment-and-**](http://www.worksafe.vic.gov.au/equipment-and-)**related-services-policy.**

**WorkSafe contracted supplier contact details:**

|  |  |
| --- | --- |
| **Independence Australia (Mobility Aids Australia)** Phone 1800 625 530 Email worksafe@mobilityaids.com.auwww.independenceaustralia.com.auwww.mobilityaids.com.au | **Aidacare**Phone 9981 2100 Email worksafe@aidacare.com.auwww.aidacare.com.au |
| **Independent Living Specialists**Phone: 1300 008 267Fax for orders: (02) 9427 4338Email: vic.admin@ilsau.com.au Website: [www.ilsau.com.au](http://www.ilsau.com.au) | **Country Care Group**Phone: 1800 843 224Email: contracts@countrycaregroup.com.auWebsite: www.countrycaregroup.com.au |
| **Mobility Plus Wheelchairs**Phone: 1300 011 000Email: orders@mobilityplus.com.auWebsite: www.mobilityplus.com.au | **Crescent Healthcare**Phone: 03 9305 1100Email: sales@crescenthealthcare.com.auWebsite: www.crescenthealthcare.com.au |

**All questions must be answered for this plan to be considered.**

**Please use block letters when completing this form and attach itemised quote for prescribed equipment.**

**Where there is insufficient space or for any further relevant information, please attach to the back of this form.**

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| --- |
| 1. **Injured worker details**
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Injured workers name Claim No.

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| --- | --- |
|       |       |

Occupation Date of birth Date of Injury

|  |  |  |
| --- | --- | --- |
|       |       |       |

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| --- |
| 1. **Equipment details**
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What equipment is being requested? eg. Wheelchair, hoist, standing frame

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| --- |
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| 1. **Recommended method of provision**
 |

[ ]  Purchase [ ]  Reissue [ ]  Hire. If hire, for how long?

|  |
| --- |
| 1. **Recommended method of provision**
 |

**[ ]** Initial provision [ ]  Replacement [ ]  Modification **\**modifications within 6 months of purchase (complete sections 7-13 only)***

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| 1. **If equipment is being replaced or modified**
 |

Type/model etc of equipment Date

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| --- | --- |
|       |       |

Limitation of current equipment

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| --- |
|       |

Purchased limitation of current equipment

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| --- | --- |
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Any further relevant information eg. reason/s for replacement

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| 1. **Equipment recommended**
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Purpose of equipment recommended. Consider intended ADLs, social, intended use (indoors, outdoors, frequency)

Expected measurable outcomes

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| --- |
| *
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Details of equipment recommended.

*List model and specifications. Consider sizes, standard features and standard accessories*

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| *
 |

Have you contacted the WorkSafe equipment contracted suppliers? Yes [ ]  No [ ]

*If no, please advise your clinical justification for not utilizing the WorkSafe Equipment contracted suppliers equipment list*

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| *
 |

Are non-standard options or non-standard customisations required? Yes [ ]  No [ ]

*If yes, please list options and supporting clinical rationale*

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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 injured worker’s environment? Yes [ ]  No [ ]

Have you considered safety of the injured worker and carers with this equipment? Yes [ ]  No [ ]

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| --- |
| 1. **Trials**
 |

Please include details of all the equipment trialed, in the first instance utilizing the WorkSafe contracted supplier equipment list, please include the specific item you are recommending

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| --- | --- | --- |
| **Equipment** | **Length and location of trial.**  | **Finding/Outcomes** |
|       |       |       |
|       |       |       |

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| 1. **Quotation**
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Has the selected WorkSafe equipment contracted supplier provided a written quotation? Yes [ ]  No [ ]

*If no, please provide clinical justification or attach relevant documentation why equipment is not available through the WorkSafe equipment contracted list*

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| 1. **Anticipated maintenance and repair**
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*Consider warranty, suppliers recommended service schedule*

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| 1. **Training requirements**
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Are there any training requirements? Yes[ ]  No [ ]

*If yes, please outline anticipated training requirements for the injured worker and/or carer(s)*

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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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| 1. **Prescribing therapist follow up services**
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Please advise if follow up services are required

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| --- | --- | --- |
| **Explain why follow up services or training is recommended** | **Frequency and duration of follow up services eg weekly follow up for two months** | **Comments, including additional travel time** |
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| 1. **Additional comments**
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| 1. **Current functional status**
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Work-related injuries and relevant medical history.

*Consider cognitive function/behaviour, prognosis, etc*

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Current function and limitations.

*Consider weight, height, mobility, upper and lower limb function, transfers, posture, functional measures*

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Social situation.

*Consider informal supports, living situation, employment, storage, etc*

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| 1. **Prescribing therapist details**
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I have discussed the information contained in the equipment prescription form with the injured worker, carers and other members of the treating team, including the equipment requested the aims, predicted outcomes, maintenance and training requirements.

Provider name

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| --- |
|       |

Provider address P/code

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|       |       |

Phone number Email address

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|       |       |

Signature *(Mandatory requirement)*

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|       |

Days/hours available Date

Date

|  |  |
| --- | --- |
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| 1. **Collection of personal information**
 |

Personal and health information collected by WorkSafe on this form will be used for the purpose of processing your Equipment prescription form, as part of the management of the claim. It may be used for other related purposes including administration and evaluation of WorkSafe’s programs.

WorkSafe may disclose any personal and health information it collects to its authorised agents, legal practitioners, contractors, consultants and other service providers engaged by it or by its authorised agents; courts tribunals; the Accident Compensation Conciliation Services, or any other person or organisation authorised by you, or law to obtain it.

Individuals have the right to access their personal information held by WorkSafe. You should contact WorkSafe’s Freedom of Information Unit. You can access the WorkSafe privacy policy at worksafe.vic.gov.au