icare™
Insurance and Care NSW

Form| FSP007

For Service Providers working with Lifetime Care and Workers Care

Equipment Request Form

Use this form for Lifetime Care and Workers Care.

1. Person's information

Name

Participant number or claim number

Contact name (if not injured person)

Contact details

2. Equipment recommendation

a) What is the equipment recommendation?

☐ Hire ☐ Purchase ☐ Other:

If hire, please provide the dates of hire

From date: Click or tap to enter a date.

To date: Click or tap to enter a date.

b) What is the equipment group according to the Professional Criteria for Prescribers? (tick all that apply)

☐ 1 ☐ 2 ☐ 3

c) Equipment – specific model and/or specifications required	Product List Number (if applicable)*	Provider / Supplier Name and ABN	Quantity	Cost (+GST and delivery)
1.				
2.				
3.				
4.				
5.				

Product list **820 – Clinical furniture, **922** - Beds& Mattresses, **963** – Compression Garments and Walking Aides (relevant for participants/workers residing in NSW only)*

Note: For equipment purchased from the icare HealthShare Product Lists that will require repairs and maintenance, please enquire about pricing when obtaining a quote so it can be included in this request.

i. If the equipment is not from icare's HealthShare product lists, give reasons why

ii. Provide off contract provider details including Name, Address, Phone Number, ABN details and quote number

3. Equipment justification

a) State the person's goal/s that relate to the item/s of equipment

b) Describe the person's need for this equipment. *Include relevant assessment results, functional abilities, prognosis, motivation, support, other equipment used or prescribed and environment(s).*

c) Please provide justification for the features/specifications of the recommended equipment

d) Compatibility with the person's environment			
i. Has the discharge destination been confirmed?	☐ Yes	☐ No	☐ N/A
ii. Is the recommended equipment compatible with the environment(s) (including storage)?	☐ Yes	☐ No	☐ N/A
iii. is the recommended equipment compatible with the current equipment being used?	☐ Yes	☐ No	
iv. Is the equipment compatible with the person's transport?	☐ Yes	☐ No	☐ N/A
v. Is the person or other relevant users (e.g. family / support workers) capable of using the recommended equipment safely and appropriately? Including care, maintenance and troubleshooting.	☐ Yes	☐ No	

If no is ticked above, please explain:

e) Trial of recommended equipment: Describe duration, location and outcome of trial. If trial was not conducted provide details.

f) Other equipment trialled or considered: *Include details of all other equipment trialled or investigated.*

Equipment	Cost	Method of Evaluation Trial = T Investigated = I	Outcome (provide reasons why not recommended
		☐ T ☐ I ☐ Loan	
		☐ T ☐ I ☐ Loan	
		☐ T ☐ I ☐ Loan	

g) What are the potential risks for the person / carer / other users if this equipment is not provided?

h) What are the potential risks to the person / carer / others from the use of this equipment and how can these risks be mitigated?

i) How often will this equipment be used?

☐ Continuously / multiple times each day	☐ 1 x daily	☐ Several times weekly
☐ 1 x a week	☐ Other, provide details:	

j) Is this person / guardian / carer aware of and in agreement with this equipment request?

☐ Yes	Date agreement received: Click or tap to enter a date.
☐ No, N.B Application will not be processed without agreement of the person / guardian / carer	

k) Has a copy of the equipment request been given to the person?

☐ Yes	☐ No	Date equipment request has been given to the person: Click or tap to enter a date.

4. Delivery Information

a) Who should be notified when the equipment is ready to be delivered?

☐ Prescriber	☐ Prescribing team	☐ Other

Please provide contact email, phone or fax:

b) Delivery address for equipment:

☐ Person's home	☐ Other, give details:

c) What set up / installation / customisation and training is required?

5. Prescriber 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

☐ This equipment has been prescribed by the treating multi-disciplinary team on Enter text and I have completed the equipment request on behalf of that team.

☐ I declare that I have been approved by icare to prescribe this category of equipment.

☐ I declare that I have assessed the person and have been supervised by Enter text. who meets the Professional Criteria for prescribers and has agreed to be nominated as my supervisor for this prescription.

☐ I declare that I have referred to icare's HealthShare Product Lists when determining the appropriate supplier for this request.

icare
Insurance and Care NSW

Prescriber details

Name

Signature

Address

Qualification

Phone

Days / hours available

ABN

Date

Email

Click or tap to enter a date.

Supervisor details

Name

Signature

Address

Qualification

Phone

Days / hours available

ABN

Date

Email

Click or tap to enter a date.

Once completed please e-mail this form to: care-requests@icare.nsw.gov.au and include the following in the subject header: Equipment Request [Participant/Worker reference number] [icare contact name]

icare NSW
GPO Box 4052, Sydney NSW 2001
General Phone Enquiries: 1300 738 586
Email: care-requests@icare.nsw.gov.au
www.icare.nsw.gov.au