****

**Equipment request form**

|  |
| --- |
| **Completing the Equipment request form and working within the National Injury Insurance Scheme, Queensland (NIISQ)*** This equipment request form may be used for all assistive technology requests.
* It is expected that providers working within the NIISQ adopt the [Clinical Framework for the Delivery of Health Services](https://www.tac.vic.gov.au/__data/assets/pdf_file/0010/27595/clinical-framework-single.pdf) within the standards and boundaries of their professional expertise.

Please send all completed request forms to requests@niis.qld.gov.au. |

 **Participant details**

|  |  |
| --- | --- |
| **Name** |  |
| **Date of Birth** |  |
| **Weight (kg)** |  | **Height (cm)** |  |
| **Contact Name***(for deliveries)* |  | **Contact Phone** |  |

 **Equipment Recommendation** *(\*Please attach quotes)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Hire** |[ ]  **Purchase** |[ ]  **Other** |  |
| If hire, state the required start and finish date |
| **Start date** |  | **Finish date** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Equipment**(specific model and/or specifications required) | **Supplier**(include quote number) | **Quantity** | **Cost**(GST and delivery) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Equipment Justification**

|  |
| --- |
| **State the participant centred goal/s that relate to this equipment prescription.** |
|  |

|  |
| --- |
| **Describe the participant’s need for this equipment (clinical justification).** **Include relevant assessment results, functional abilities, prognosis, motivation, support, other equipment used or prescribed and environment/s and potential risks for participant/care/other users if this equipment is not provided.**  |
|  |

|  |
| --- |
| **Please provide clinical justification for any customisation and/or accessories that have been prescribed.**  |
| ***Customisation/accessory*** | ***Justification***  |
|  |  |
|  |  |
|  |  |
| *<Add extra lines as required>* |  |

|  |
| --- |
| **Is the recommended equipment compatible with the participant’s environment/s (including storage, compatibility with other equipment, transport etc.)?** |
| **Yes** |[ ]  **No** |[ ]
| **If no, please provide comment.** |
|  |
| **Does the recommended equipment have an appropriate safe working limit (SWL) for the participant (if applicable)?** |
| **Yes** |[ ]  **No** |[ ]  **NA** |[ ]
| **If no, please provide comment.** |
|  |

|  |
| --- |
| **Describe duration, location and outcome of trial of the recommended equipment. Include details of other equipment trialled or considered including cost and why not recommended.**  |
| **Item** |  |
| **Duration and location of trial** |  |
| **Cost** |  |
| **Outcome of trial** |
|  |

|  |
| --- |
| **Describe duration, location and outcome of trial of the recommended equipment. Include details of other equipment trialled or considered including cost and why not recommended.**  |
| **Item** |  |
| **Duration and location of trial** |  |
| **Cost** |  |
| **Outcome of trial** |
|  |

|  |
| --- |
| **Describe duration, location and outcome of trial of the recommended equipment. Include details of other equipment trialled or considered including cost and why not recommended.**  |
| **Item** |  |
| **Duration and location of trial** |  |
| **Cost** |  |
| **Outcome of trial** |
|  |

|  |
| --- |
| **Other supporting information.** (Please attached documents if required) |
|  |

**Delivery Information**

|  |
| --- |
| **Who should be notified when the equipment is ready to be delivered?** |
| **Participant** |[ ]  **Prescriber** |[ ]  **Other** |  |
| **Delivery address** |  |
| **Setup/ installation/ customisation and training required** | *<Provide details of setup/installation and/or training required>* |

**Prescriber Declaration**

|  |  |
| --- | --- |
| **Name** |  |
| **Profession & position** |  |
| **Contact Phone** |  |
| **Contact Email** |  |
| **Has a copy of this request been provided to the participant?** | Yes [ ]  No [ ]  |
| **Does the participant confirm that:** |
| **They actively participated in the assessment and/or trial** | Yes [ ]  No [ ]  |
| **The features, options and/or any appropriate alternatives have been adequately explained to them** | Yes [ ]  No [ ]  |
| **They believe the item/s meets their needs** | Yes [ ]  No [ ]  |
| **Date** |  |