This form is for use by Framework Occupational Therapists providing services to TAC and WorkSafe. The information in this form is for use by the organisation which has requested it and will not otherwise be exchanged with any other party, except in accordance with law. Please see section 12 of this form for further information.

**IMPORTANT**

* Please type or use block letters and **ensure that all sections are complete.** All incomplete forms will be returned, so please give reasons if you are unable to complete a section.
* Please attach itemised quote(s) 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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This form must be completed for all requests for items listed below but not exclusive to:

wheelchairs, pressure cushions, powered conversion kits, hoists, scooters, bikes and recumbent trikes, beds, mattresses, standing frames, tilt tables, treatment couches, large exercise equipment, lounge chairs, custom toilet/shower/commode chairs. This form must also be completed for repairs or modifications to these existing equipment items.

Providers are required to contact the Equipment Contractors to conduct trials of equipment. Details of TAC and WorkSafe Equipment Contractors are available from [www.tac.vic.gov.au](http://www.tac.vic.gov.au) and [www.worksafe.vic.gov.au](http://www.worksafe.vic.gov.au)

1. Client/worker details

|  |  |  |
| --- | --- | --- |
| Client/Worker Name |  | Type of claim |
|       |  | TAC [ ]   | WorkSafe [ ]  Agent:       |
| Client/worker address |  | Claim number |  | Telephone number |
|       |  |       |  |       |
|       |  | Date of Birth  |  | Date of injury |
|       |  |       /       /       |  |       /       /       |
|       Postcode       |  | Employer |  | Employer telephone number |
|   |  |       |  |       |
| Current Occupation:  |       |  | Date of Assessment  |  | Date Report submitted  |
| Pre-injury Occupation:  |       |  |       /       /       |  |       /       /       |
| Delivery Contact Person  |  | Delivery Contact Telephone Number |
|       |  |       |
| Delivery Address and instructions:  |  |  |
|       |

2. What equipment is being requested?

*e.g. wheelchair, hoist, standing frame*

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**Recommended method of provision**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  Purchase | [ ]  Reissue | [ ]  Hire | *If hire, for how long?* |       |

Type of supply

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Initial provision | [ ]  Replacement | [ ]  Modification | [ ]  Modifications within 6 months of purchase *(complete sections 4, 5, 6, 7, 8 only)* |

 *If equipment is being replaced or modified, please specify the following:*

|  |  |  |
| --- | --- | --- |
| Type/model etc of equipment |  | Date purchased |
|       |  |       /       /       |
| Limitation of current equipment |
|       |

Any further relevant information *e.g. reason(s) for replacement*

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**3. Current level of function**

Transport accident or work-related injuries and relevant medical history *Consider cognitive function/behaviour, prognosis*

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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, driving, storage*

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4. Equipment recommended

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

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Expected measurable outcomes. *Please be specific regarding how the equipment will maximise functional independence*

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Details of equipment recommended *List model and specifications. Consider sizes, standard features and standard accessories*

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

*If yes, please list options and supporting clinical rationale if requesting TAC/WorkSafe funding*

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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 client/worker’s Environment? |  [ ]  Yes |  [ ]  No |  |
| Have you considered the safety of the client/worker and carers with this equipment? |  [ ]  Yes |  [ ]  No |  |
| Has there been multidisciplinary team consensus? |  [ ]  Yes |  [ ]  No |  |
| Is this equipment available from the TAC/WorkSafe contracted equipment suppliers? |  [ ]  Yes |  [ ]  No |  |
| (If no, Claims Manager will refer order to the HSG Equipment Brokerage Team.) |

Additional comments *Please provide details where the response to the above is “no”*

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5. Trials

*Include*, **where conducted**, *the outcomes of all equipment trialled, including the specific item(s) you are recommending*

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| **Equipment** | **Date and location of trial** | **Findings** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

6. Quotation

|  |  |  |
| --- | --- | --- |
| Has the selected TAC/WorkSafe Equipment Contractor provided a written quotation? |  [ ]  Yes |  [ ]  No |

*If no, please provide details or attach relevant documentation why equipment is not available through the HSG Equipment Contractors*

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7. Anticipated maintenance and repair

*Consider warranty, supplier’s recommended service schedule*

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8. Are there any training requirements? [ ]  Yes [ ]  No

*If yes, please outline anticipated training requirements for the client/worker and/or carers*

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**9. Assessor follow-up services**

Detail the specific follow-up actions that are required to facilitate the achievement of goals and recommendations identified. The clinical justification for these services should be clear from your recommendations.

The TAC/WorkSafe Agent is able to approve a maximum of 6 hours to provide follow–up services. Detail the number, frequency and duration of follow-up services requested.

|  |  |  |
| --- | --- | --- |
| **Details of follow-up actions or training recommended** | **Frequency and duration of follow-up services** | **Comments including additional travel time required for assessor and associated request**  |
|       |       |       |
|       |       |       |
|       |       |       |

Is a referral for further occupational therapy services required?

Referral is required if follow-up is anticipated to be greater than 6 hours. If yes, please outline the areas that need to be addressed

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10. Discussion with treating healthcare professionals

Provide the outcomes of the discussions you have had with the treating healthcare professionals about your recommendations. Include any differences in opinion or support for your recommendations.

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11. Additional comments/other attached information

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| [ ]  Other attached information or additional comments, please specify       |

Assessor Occupational Therapist details

I have discussed the information contained in the *Equipment Report* with the client/worker or carers and other members of the treating team, including the equipment requested, the aims, predicted outcomes, maintenance and training requirements.

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| --- | --- | --- |
| Provider name, address and phone no. *Use practice stamp where possible* |  | Signature |
|       |  |  |
|       |  |  |
|       |  | Days/hours available |
|       |  |       |
|       |  | Date |
|       |  |      /     /      |

12. Personal and health information

TAC

The TAC will retain the information provided and may use or disclose it to make further inquiries or assist in the ongoing management of the claim or any claim for common law damages. The TAC may also be required by law to disclose this information. Without this information the TAC may be unable to determine entitlements or assess whether treatment is reasonable and may not be able to approve further benefits and treatment

**WorkSafe**

Personal and health information collected by WorkSafe on this form is used for the purpose of processing, assessing and managing claims under the *Accident Compensation Act 1985* (the Act). It may also be used for other related purposes including legal proceedings arising under the Act, to assist with a worker’s rehabilitation and return to work and to assist WorkSafe and its Agents to better manage claims generally.

For the purposes of processing, assessing and managing a claim, WorkSafe and the Agent of the injured worker’s employer may disclose personal and health information about the worker to each other and to the following types of organisations:

* employees, contractors and agents of WorkSafe and WorkSafe Agents;
* employers of the injured worker;
* solicitors, medical practitioners and other health service providers, private investigators, loss adjusters and other service providers acting on behalf of WorkSafe or the Agent in relation to the claim;
* the Accident Compensation Conciliation Service and Medical Panels;
* a court or tribunal in the course of criminal proceedings or any proceedings under any of the Acts which WorkSafe administers;
* any other person, organisation or government agency authorised by you, or by law, to obtain the information.

An individual may request access to personal and health information about them collected by WorkSafe or an Agent by contacting the Agent.

WorkSafe's Privacy Policy is available at the nearest WorkSafe office or at [www.worksafe.vic.gov.au](http://www.worksafe.vic.gov.au).