**Logo

Description automatically generated**

**Equipment request form**

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| **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](mailto: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) |
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**Equipment Justification**

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| **State the participant centred goal/s that relate to this equipment prescription.** |
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| **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.** |
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| --- | --- |
| **Please provide clinical justification for any customisation and/or accessories that have been prescribed.** | |
| ***Customisation/accessory*** | ***Justification*** |
|  |  |
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| *<Add extra lines as required>* |  |

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| --- | --- | --- | --- | --- | --- |
| **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** | |
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| **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** | |  |