EnableNSW

Footwear and Orthoses Equipment Request Form

When to use this form

Use this form if you cannot submit this request using EnableNSW Online.

Find out more at www.enable.health.nsw.gov.au/online

Filling in this form

You can complete this form on your computer, print and sign it. If you need to print this form ensure you:

- Use blue or black pen
- Print in BLOCK LETTERS
- Sign the prescriber declaration

Eligibility

An EnableNSW application form is required to assess a person's eligibility. A new application form is required every two years **OR** if the person's circumstances change. Application forms can be accessed online at www.enable.health.nsw.gov.au/for_individuals/applying-to-EnableNSW. If we do not have an application form at the time of reviewing this request, the request may go on hold and delay the outcome.

Important information before making this request

- You must be an eligible prescriber for this type of equipment **AND**,
- the equipment requested must meet the applicable funding criteria. You can read more about this at www.enable.health.nsw.gov.au/prescribers/forms/footwear_and_orthotics
- You must attach a quote to this form for the equipment you are requesting.

For more information

Go to our website www.enable.health.nsw.gov.au or call us on 1800 Enable (1800 362 253)

Privacy

We collect your personal information and the health information of patients to allow EnableNSW to manage and provide its services. This allows us to:

- Assess your eligibility to prescribe assistive technology in accordance with the relevant funding criteria
- Contact you if more clinical information is required about the request, as well as provide status updates about the request
- Share contact details with a supplier if additional support is required for set up of equipment when necessary.

If you would like to view or make changes to your information, please send an email to enable@health.nsw.gov.au or call 1800 Enable (1800 362 253).

A. Request type

☐ New request ☐ Amendment to existing request ☐ Change in clinical prescription for the next order

B. Person information

1. Person details

Title ____ First name ____ Surname ____

Date of birth D D/M M/Y Y Y Y

Medicare card number ☐☐☐☐ ☐☐☐☐☐ ☐ Ref no. ☐

Person's address ____

State ____ Postcode ____

2. Delivery details

All requests require the person to attend an appointment with the Footwear and Orthotic supplier to collect their equipment

Confirm the supplier/prescriber will contact the person/carer for appointments ☐ Yes

Where will the equipment be delivered to? *Please select one only*

☐ Person's address ***Go to question 3***

☐ Other, please specify where the equipment will be delivered ____

Contact name ____ Contact phone number ( )

Delivery address (if not person's address) ____

State ____ Postcode ____

C. Diagnosis

3. What is the primary diagnosis in relation to the requested equipment?

E.g. R transmetatarsal amputation (2020) following osteomyelitis secondary to a diabetic foot infection.

4. Provide other relevant diagnosis/co-morbidities

E.g. T2DM; HTN; hypercholesterolaemia; amputation L 2nd toe; amputation L 5th toe

D. Equipment category

5. What equipment are you requesting? *Select all items being requested*

- ☐ Footwear - prefabricated medical grade
- ☑ Footwear - custom made
- ☐ Footwear modification
- ☐ Other orthosis, brace or splint
- ☐ Lower limb orthosis
- ☐ Upper limb orthosis
- ☐ Spinal orthosis or abdominal orthosis

E. Equipment recommendation

6. List recommended orthoses and/or footwear. Provide brand/model (for prefabricated items), description of equipment e.g. AFO, supplier details, price and quote for the requested equipment.

Note you must attach a quote for all items in this request

Equipment – specifications required	Preferred supplier details	Qty	Cost (inc GST & delivery)	Quote number
	Walk Easy Pedorthics - See quote		$	
			$	
			$	
			$	
			$	

7. For prefabricated orthoses confirm the requested equipment complies with the relevant Australian or International Standards and/or has Therapeutic Goods Administration registration (class 1 medical devices)

☑ N/A - I have selected custom made equipment ☐ Yes ☐ No

F. Equipment goal(s)

8. Confirm the person requires footwear and/or orthoses to: *Select all that apply*

- ☑ Increase independence in mobility, transfers and/or core activities of daily living in the home and local community
- ☑ Improve safety in mobility, transfers and/or core activities of daily living in the home and local community
- ☑ Reduce immediate risk of falls/injury
- ☑ Prevent ulceration and/or reduce symptoms associated with the person's condition

G. Equipment justification

9. Date of assessment/review for this equipment request D D/M M/Y Y Y Y

10. For replacement footwear or orthoses requests complete the following: *Select N/A if new request*

- ☐ N/A - Equipment has not been funded by EnableNSW previously
- ☐ Current prescription is no longer clinically appropriate
- ☐ Current equipment is beyond repair and unsafe to use
- ☐ Current equipment is due for replacement due to general wear and tear

11. For Orthoses requests provide clinical justification and describe the structural and/or functional characteristics (including description of any deformity) requiring support or correction. *Where appropriate attach relevant supporting documentation such as foot measurements, tracings, photos or reports*

Prefab not suitable for patient as toe filler required on right foot and patient has dense peripheral neuropathy. CMO will reduce risk of future diabetic foot ulcerations as orthotic top cover made of plastazote.

H. Equipment justification: footwear

12. For ALL footwear requests confirm the person: *Select all that apply*

- ☐ N/A – I am not requesting footwear
- ☑ Has an abnormal foot shape that is unable to fit into regular footwear
- ☑ Has an increased risk of amputation as a result of peripheral neuropathy (failed 10g monofilament) and/or ischaemia (e.g. impalpable pulses, ABI <0.8, or vascular study) plus deformity and/or previous foot ulceration
- ☐ Has chronic oedema that is under medical/professional management
- ☑ Has severe limitations in ability to perform activities of daily living
- ☐ Requires footwear to accommodate a lower limb orthosis
- ☑ Has footwear that requires modifications that are beyond what is achievable with regular footwear
- ☐ Has footwear that is requested as an alternate to an ankle foot orthosis

13. If requesting custom made footwear provide additional clinical justification why prefabricated options do not meet the person's specific clinical need

E.g 56 year old female with TMT amputation 2020 secondary to diabetic foot infection leading to osteomyelitis and long term hospitalisation. Patient had multiple washouts of ulcer site and due to non healing and ongoing infection a TMT was completed. Patient wound now healed. Wearing DARCO shoe with semi compressed felt building up a forefoot (similar to toe filler). Requires CFW for TMT amputation site and also rocker sole for both feet to accommodate for modified biomechanics. LF has had two digital amputations and hammer toe deformities remain. Likely future ulceration site if nil rocker sole modification.

I. Safe use, care and maintenance

14. Confirm the person and/or family/carer will receive education in the:

- ☑ Safe use of the requested equipment
- ☑ Correct care and maintenance of the requested equipment

Go to next page and complete Section J. Prescriber Eligibility and Declaration

J. Prescriber eligibility and declaration

15. Prescriber eligibility

Confirm you have assessed the person and have the qualification and level of experience to prescribe this equipment in line with the relevant EnableNSW Funding Criteria and Professional Criteria for Prescribers.

☐ Yes ***Go to question 16***

☐ No – I do not have the level of experience to prescribe this type of equipment as required by the funding criteria.

The assessment of the person and the equipment request has been supervised by an eligible EnableNSW prescriber. Provide your supervisor's name and email address

Supervisor's name | Supervisor's email

16. Prescriber declaration

I confirm the following:

- The person/carer agrees with this request
- A copy of this request will be provided to the person/carer
- As a health professional, I cannot also be the equipment supplier for the same request. This may include but is not limited to a personal or professional relationship with or material interest in the supplier or manufacturer of the equipment listed on this request

I declare that:

- I have the qualification and experience to prescribe this equipment or, I have been supervised by an eligible EnableNSW prescriber for this type of equipment
- All information I have supplied on this application is true and correct to the best of my knowledge at the time of assessment.

Prescriber information:

Prescriber name

Place of work

Address

State Postcode

Qualification | AHPRA registration number

Phone number ( ) | Email

Signature | Date D D/M M/Y Y Y Y

17. Other contacts (optional)

Complete this question if you would like to provide details of any other relevant health professionals who will be involved with the management and monitoring of the person's condition.

Other contact 1

Name

Place of work

Address

State Postcode

Qualification/role | AHPRA registration number

Phone number ( ) | Email

Other contact 2

Name

Place of work

Address

State Postcode

Qualification/role | AHPRA registration number

Phone number ( ) | Email

Submitting this request

Submit this form and any relevant clinical documentation to enable@health.nsw.gov.au, please include the following in your subject line **Equipment type_Person name_Date submitted** i.e *Footwear request_John Smith_01.01.2022*