Orthoses & Footwear (a.k.a Medical Grade or Custom Footwear, Pedorthic Footwear, Orthopaedic or Surgical Footwear)
Equipment Request Form

NSW GOVERNMENT | HealthShare EnableNSW

☐ **New Request** ☐ **Amendment to existing request** ☐ **Replacement request**
Type of Equipment requested ☐ **Orthoses** ☐ **Medical Grade Footwear**

1. PERSON INFORMATION

First Name enter text. **Last Name** enter text. **Title** Choose an item or enter text **Date of birth:** enter text.	**Address** enter text. **Suburb & Post Code** enter text. **Phone** enter text. **Mobile** enter text.
Contact person (if not client) **and relationship to client** enter text.	**Contact Person contact details** enter text.
(a) Presenting diagnosis requiring support or correction (if known, include date of injury/diagnosis or onset) enter text.	**Co-morbidities** enter text.

(b) What body location requires an orthosis (select all that apply)?
☐ Lower Limb Right ☐ Lower Limb Left ☐ Upper Limb Right ☐ Upper Limb Left ☐ Spine/torso
☐ Other: enter text.

2. IDENTIFICATION OF NEED

(a) Provide the clinical reasoning and describe the structural and/or functional characteristics for why this person requires footwear/orthoses- attach any relevant supporting documentation such as foot measurements or tracings, photos, other reports:
enter text.

(b) Goal of orthoses and/or Footwear provision (select all that apply):
☐ Increased independence in mobility, transfers and/or core activities of daily living in the home and local community
☐ Improved safety in mobility, transfers and/or core activities of daily living in the home and local community
☐ Prevent ulceration and/or reduce symptoms associated with the person's condition
☐ Other: enter text.

(c) How often will the orthosis/footwear be used?
☐ Continually or multiple times each day ☐ 1x daily ☐ 1 – 2 x weekly
☐ Additional Comment: enter text.

3. ORTHOSES / FOOTWEAR JUSTIFICATION

(a) Date of assessment or review: enter date

(b) Is the person at risk of falls and/or injury without the requested orthoses/footwear?
☐ YES ☐ NO
If YES, please describe: enter text.

(c) Is the person at risk of ulceration or is there a pre-ulcerative pressure lesion?
☐ YES ☐ NO

(d) If you are requesting a replacement item please select from the following:
☐ Current prescription is no longer clinically appropriate
☐ Current Orthoses/Footwear are beyond repair and unsafe for use
☐ Current Orthoses/Footwear are due for replacement due to general wear and tear

PLEASE COMPLETE ALL RELEVANT QUESTIONS

ORTHOSES

What other cost effective orthotic options have been considered and why these are not appropriate?

enter text.

MEDICAL GRADE FOOTWEAR – MUST be completed for ALL Footwear requests

Have you considered prefabricated Medical Grade Footwear?

☐ YES ☐ NO

Please provide clinical justification if prefabricated Medical Grade Footwear options are not appropriate?

enter text.

Please select which category of Footwear the request meets:

Category 1

Does the person have an abnormal foot shape/deformity that is unable to fit into regular footwear?

☐ YES ☐ NO

If YES, please describe: enter text.

PLUS at least one of the following (select all that apply)

☐ 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

☐ Chronic oedema resulting in inability to fit into regular footwear, despite being under medical/professional management

☐ Severe limitations in ability to perform activities of daily living

Please provide detail: enter text.

Category 2

Does the person require footwear to accommodate orthoses?

☐ YES ☐ NO

If YES, please confirm all of the following:

☐ Person has requested, or is currently using, custom lower limb orthoses that meet the EnableNSW funding criteria

☐ Person has a need for an extra depth or extra width that cannot be accommodated in regular footwear, including through purchase of split sizes

☐ Person has a history of, or is at risk of, serious injury as a result of being unable to wear orthoses due to inappropriate footwear

Category 3

Does the person's Footwear require modifications that are beyond what is achievable with regular footwear?

☐ YES ☐ NO

If YES, please describe the modifications required and provide clinical justification: enter text.

Category 4

Is the footwear requested as an alternative to Ankle Foot Orthoses?

☐ YES ☐ NO

If YES, please provide clinical justification: enter text.

4. ORTHOSES AND/OR FOOTWEAR RECOMMENDATION

Provide details of orthoses and/or footwear specifications plus written quotes from supplier.

Equipment –specifications required	Preferred supplier details	Qty	Cost (inc GST & Del)	Quote number
1. enter text.	enter text.	Choose an item.	**$** enter	enter
2. enter text.	enter text.	Choose an item.	**$** enter	enter

3. enter text.	enter text.	Choose an item.	**$** enter	enter
4. enter text.	enter text.	Choose an item.	**$** enter	enter

5. TRIAL OUTCOMES

Please complete the following sections for <u>all</u> orthotic and/or footwear requests

Has the person used this equipment before and has it achieved the goals identified?

☐ YES, achieved goals ☐ YES, did not achieve goals ☐ NO, not used before

If YES, please comment on the outcomes:

enter text.

Is the person/carer(s) capable of using the recommended equipment safely and appropriately?

☐ YES ☐ NO

6. DELIVERY INFORMATION

Supplier/prescriber to contact person for an appointment

7. PRESCRIBER DECLARATION

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

OR

☐ I declare that I have assessed the person and have been supervised by enter text. who is an eligible prescriber and has agreed to be nominated as my supervisor for this prescription

AND

☐ I confirm that the person / carer is in agreement with this request

☐ I confirm a copy of this request will be provided to the person / carer

☐ I confirm that all information I have supplied on this application is true and correct, to the best of my knowledge at the time of assessment

☐ I have read and understand my responsibilities and obligations as provided in the declaration above.

Prescriber name: enter	**Supervisor name (if applicable):** enter
Qualification: enter	**Qualification:** enter
AHPRA Registration # if applicable: enter	**AHPRA Registration # if applicable:** enter
Phone: enter	**Phone:** enter
Email: enter	**Email:** enter
Name of service: enter	**Name of service:** enter
Days/Hours available: enter	**Days/Hours available:** enter
Signature: enter	**Signature:** enter
Date: enter date	**Date:** enter date

NB: Incomplete forms will be sent back. Please ensure all contact details are provided.