Compression Garment Request Form

NSW GOVERNMENT | HealthShare EnableNSW

This form should be used to request the first order of compression garments and amended requests. Refer to the Funding Criteria ***here*** for information regarding eligible persons, eligible prescribers and equipment provided.

☐ **New Request** ☐ **Amendment to existing order (Date:)**
☐ **Change in clinical prescription for next order**

1. PERSONAL INFORMATION

Name	**Last Name** **First Name**	**Address** **Suburb & Post Code**	
Title	☐ **Mr** ☐ **Mrs** ☐ **Ms** ☐ **Miss** ☐ **Other**	**Date of birth:**	
Phone		**Mobile**	
Alternative Contact person		**Relationship**	**Contact details**

Diagnosis
Type of Lymphoedema:
☐ 1° Lymphoedema ☐ 2° Lymphoedema ☐ Venous insufficiency ☐ Lipoedema ☐ Other

Location of Lymphoedema:
☐ Left Upper Limb ☐ Right Upper Limb ☐ Left Lower Limb ☐ Right Lower Limb
☐ Truncal Lymphoedema of the ☐ Chest ☐ Back ☐ Abdomen ☐ Buttocks ☐ Breast ☐ Genital
☐ Head and Neck

Severity of Lymphoedema:
☐ Mild ☐ Moderate ☐ Severe

Symptoms
☐ Swelling ☐ Heaviness ☐ Numbness ☐ Tightness ☐ Pain ☐ Skin changes
☐ Pins and needles ☐ Reduced mobility ☐ Functional limitation ☐ Other

Cause(s)	**Co-morbidities**	**Date of onset**

2. COMPRESSION GARMENT RECOMMENDATION *(Including Delivery Options)*

Product Code	**Description** * RTW = Ready to wear			**Supplier**	**Quantity** Each	Pair	**Cost**	**Contract / Quote #**
		RTW ☐	Custom ☐				$	
		RTW ☐	Custom ☐				$	
		RTW ☐	Custom ☐				$	
		RTW ☐	Custom ☐				$	
		RTW ☐	Custom ☐				$	
Will two (2) deliveries be required for this order? (If a second delivery is required to ensure correct fit, please ensure cost is included in the quote)							Yes ☐ No ☐	
TOTAL COST							$	

- **Specify quantity and cost per affected body part per 6 months**
- **New quote is required every 6 months if applicable. Quantities / Quote should reflect order for 6 months**
- **Indicate cost per garment or per pair of garments**

3. IDENTIFICATION OF NEED

(a) Goal of compression garment provision (*tick all that apply*):

- ☐ Assist person to perform activities of daily living
- ☐ Assist person to wear clothes and dress independently
- ☐ Assist person to wear shoes
- ☐ Assist person to mobilise safely
- ☐ Assist with bed mobility and transfers
- ☐ Reduce the risk of falls
- ☐ Other

(b) How often will the compression garment(s) be used?

☐ Continuously every day ☐ Other (please describe)

4. COMPRESSION GARMENT JUSTIFICATION

(a) Date of assessment

(b) Describe the person's need for this equipment.

- ☐ Reduce and maintain swelling and other lymphoedema symptoms
- ☐ Other

AND person's oedema is now stable as:

☐ Swelling is minimised ☐ Pitting oedema is absent or minimal ☐ Shape distortion has been optimized

☐ Other

(c) Additional clinical justification if custom made or non-contract items are requested

(d) Compression garment provision and ongoing care	
• Person/carer is aware of supply allocation through EnableNSW and how they can purchase additional supplies as required	☐ Yes ☐ No
• Person is compliant with wearing compression garments	☐ Yes ☐ No
• Person/carer is capable of using compression garments safely and appropriately	☐ Yes ☐ No
• Person /carer understands how to care and maintain compression garments	☐ Yes ☐ No
• Person /carer has the ability to seek assistance from clinician as required	☐ Yes ☐ No
• Person /carer has details of local contact for ongoing clinical management if person is being discharged to another area	☐ Yes ☐ No ☐ N/A
• Please provide name and contact details of local contact	

5.TRIAL OUTCOMES

- Has the prescribed compression garment(s) been trialed? ☐ Yes ☐ No

Duration of trial

- Has the trial of the prescribed compression garment(s) been successful? ☐ Yes ☐ No
- Describe how each feature/specification of the recommended compression garment(s) will meet the person's needs in the most cost effective, clinically appropriate way

- Has person trialled other compression garment(s) previously? ☐ Yes ☐ No

If yes, provide more information on the outcome of the trial:

6. DELIVERY INFORMATION

(a) Special instructions when funding approved:

☐ Prescriber to be informed as person needs to be re-measured

☐ Place order as re-measure not required

(b) Who should be notified when the compression garment(s) is/are ready to be delivered?

☐ Person/Carer ☐ Prescriber

☐ Other. Provide contact name, relationship, phone, email

(c) Delivery address for compression garment(s):

☐ Person's home address ☐ Prescriber's workplace address:

☐ Other, provide details and reasons

7. PRESCRIBER DECLARATION *(Tick all that apply)*

☐ I confirm that the person/carer is in agreement with this request
A copy of this request has been provided to person/carer ☐ Yes ☐ No

☐ I understand 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 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 and have

☐ Completed Level 1 Lymphoedema Management Course (recognised by the Australasian Lymphology Association)

OR

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

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

Prescriber name: **Qualification:** **AHPRA Registration Number:** **Phone:** **Email:** **Name of Service:** **Days/Hours available:** **Date:**	***If applicable:*** **Supervisor name:** **Qualification:** **AHPRA Registration Number:** **Phone:** **Email:** **Name of Service:** **Days/Hours available:** **Date:**

Note: Incomplete forms will not be processed. Please ensure all correct details are provided.

Please email requests from a work email address to: enable@health.nsw.gov.au

Thank you