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**Instructions**

Use this form to assess and recommend assistive technology to support a person in achieving goals towards participation in personal, family, home and community activities. Refer to the [TAC provider guidelines](https://www.tac.vic.gov.au/providers/working-with-tac-clients/guidelines).

The form is required for requests for hire, purchase or modifications of the following equipment:

|  |  |  |
| --- | --- | --- |
| * Beds
* Bikes
* Custom toilet, shower orcommode chairs
* Hoists
* Large exercise equipment
* Lift recliners
 | * Mainstream technology (tablets, smartphones, computers)
* Mattresses
* Powered conversion kits
* Pressure cushions
* Ramps
* Recumbent trikes
 | * Scooters
* Shower trolleys
* Standing frames
* Tilt tables
* Treatment couches
* Wheelchairs
* Any other specialised or customised equipment item
 |

Where appropriate please contact the TAC equipment contractors below to conduct trials of equipment. For customised items, attach a standardised quote from the equipment contractor, who can use our [Assistive technology quote template](https://www.tac.vic.gov.au/__data/assets/word_doc/0004/549607/Assistive-technology-quote-template.docx) or their own business format (if it supplies the same information as our template).

|  |  |
| --- | --- |
| **Aidacare**Phone: 9981 2100 tac@aidacare.com.au[www.aidacare.com.au](http://www.aidacare.com.au)**Independence Australia** (Mobility Aids Australia) Phone: 1800 625 530 tac@mobilityaids.com.au [www.independenceaustralia.com.au](http://www.independenceaustralia.com.au/)[www.mobilityaids.com.au](http://www.mobilityaids.com.au) | **Country Care Group**Phone: 1800 843 224 contracts@countrycaregroup.com.au [www.countrycaregroup.com.au](http://www.countrycaregroup.com.au)**Independent Living Specialists, ILS** (includes Leef Mobility stores)Phone: 1300 008 267vic.admin@ilsau.com.au [www.ilsau.com.au](http://www.ilsau.com.au) |

**Section 1**

**TAC client details**

|  |  |
| --- | --- |
| First name |   |

|  |  |
| --- | --- |
| Last name |   |

|  |  |  |  |
| --- | --- | --- | --- |
| TAC claim number |   | Date of accident |  / /  |

|  |  |
| --- | --- |
| Date of birth |  / /  |

|  |  |
| --- | --- |
| Street name and number |   |

|  |  |  |  |
| --- | --- | --- | --- |
| Suburb/Town |   | Post code |   |

|  |  |
| --- | --- |
| Client phone number |   |

|  |  |
| --- | --- |
| Client email address |   |

|  |  |
| --- | --- |
| Key contact if not client |   |

|  |  |
| --- | --- |
| Key contact phone number |   |

|  |  |
| --- | --- |
| Relationship of key contact |   |

(e.g. parent, partner, guardian)

|  |  |
| --- | --- |
| Delivery contact person |   |

|  |  |
| --- | --- |
| Delivery contact phone number |   |

|  |  |
| --- | --- |
| Delivery street name and number |   |

|  |  |  |  |
| --- | --- | --- | --- |
| Delivery suburb/town |   | Post code |   |

Delivery instructions

|  |
| --- |
|   |

|  |  |  |  |
| --- | --- | --- | --- |
| Date of assessment |  / /  | Date report submitted |  / /  |

# Section 2

## Current situation

### Injuries and medical history

Briefly outline the person’s transport accident injuries and relevant medical history. Consider physical, cognitive, sensory, communication and behavioural/emotional issues relevant for assistive technology assessment.

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### Social situation

Briefly describe accommodation type, person living alone/with others, any other formal or informal supports, stability/permanency of accommodation and if there are any plans for change in the future.

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|   |

### Current capabilities and participation in life roles

Provide a general overview of the person’s level of function in the following areas: transfers, mobility, pressure management, personal care, domestic tasks and community access. Consider employment, education, recreation interests. Include details specifically relevant to the equipment recommended.

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### Functional limitations

Based on capabilities, describe specific functional limitations that might impact upon selection and use of assistive technology. Consider height, weight, upper and lower limb function, posture, balance, cognitive, communication and behavioural or emotional issues resulting from the transport accident injury.

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Outline any cultural or other considerations in the provision or use of assistive technology.

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# Section 3

## Personal goals

Briefly outline the person’s goals that the recommended assistive technology will enable.

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# Section 4

## Method of provision

|  |  |
| --- | --- |
| How will the assistive technology be provided? |   |

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| **If hire**, for how long? |   |

Please consider purchase of assistive technology if hire is for an extended period of time and the hire cost will exceed the cost to purchase the item.

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| --- | --- |
| Type of supply |   |

If assistive technology is being replaced or modified, please specify the following:

|  |  |
| --- | --- |
| Type and model of current assistive technology |   |

|  |  |
| --- | --- |
| Date purchased |  / /  |

Limitation of current assistive technology and reasons for replacement or modification.

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| --- |
|   |

Insert photo(s) of current assistive technology if appropriate.

|  |
| --- |
|  |

If the assistive technology is being modified, will there be an impact on the item’s warranty/maintenance?

|  |
| --- |
|   |

If the assistive technology is replacing existing items, has removal/disposal of current item been considered?

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|   |

Provide relevant details. Is the item suitable for re-use? Does the person need assistance for removal of item?
Is there a cost?

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| --- |
|   |

**Section 5**

**Trials**

|  |  |
| --- | --- |
| Did you make your recommendation after trialling products from the TAC Equipment Contractors? |   |

**If no**, please provide clinical reasoning to support why the TAC Equipment Contactors’ products did not meet the client’s needs.

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|   |

Please note that trialling products from the TAC Equipment Contractors is mandatory. Failure to do so without clinical justification will result in the form being returned for further information.

### Details of trials

|  |  |  |
| --- | --- | --- |
| Items trialledInclude all trials, including the assistive technology you recommend in section 6 | Length and location of trialInclude assistive technology provider name | Outcomes and client/carer feedback |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |

# Section 6

## Recommendations

Provide details of recommended assistive technology, including model, accessories and specifications. List all items.

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Insert photo(s) of recommended assistive technology if appropriate.

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### Clinical justification

Please list each specific assistive technology item and provide a brief statement with the clinical justification for each.

Base clinical justification on the information gained through client assessment, review of the different strategies and assistive technology available and the outcomes of the trials. Include the following:

Feedback provided by the **client’s support** team, where relevant.

Why this assistive technology is the most **cost-effective option**.

How this assistive technology will support the client to achieve their **functional goals both now and in the future**.

Whether **non-standard options or non-standard customisations** are required. If yes, please list and justify.

How assistive technology will impact upon **funded support hours** (e.g. a personal alarm to decrease supervision hours).

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|   |

Insert photo(s) if appropriate.

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# Section 7

## Discussion with key providers

Provide the outcomes of discussions with the person’s other treating healthcare professionals or service providers about your recommendations. Include any differences in opinion or support for your recommendations.

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# Section 8

## Use of assistive technology

|  |  |
| --- | --- |
| Have you considered day-to-day transportation of the equipment? |   |

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| --- | --- |
| Have you considered compatibility with existing equipment and the person’s environment? |   |

|  |  |
| --- | --- |
| Have you considered the safety of the person and carers using this assistive technology? |   |

|  |  |
| --- | --- |
| Could the use of this assistive technology be considered a potential restrictive practice? |   |

|  |  |
| --- | --- |
| **If yes**, has there been a risk assessment conducted or behaviour support plan developed? |   |

|  |  |
| --- | --- |
| Are there issues of cleaning/infection control to be considered? |   |

|  |  |
| --- | --- |
| Is this assistive technology available from the TAC Equipment Contractors? |   |

**If no**, the TAC Claims Manager will refer the order to the Equipment Brokerage Team.

Please provide more information on the above items if required (e.g. risk assessment or behaviour support plan).

Insert photo(s) if appropriate.

|  |
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# Section 9

## Quotation

Complete this section only for customised items and items that do not appear on the Equipment List.

|  |  |
| --- | --- |
| Has the selected TAC Equipment Contractor provided a written quotation? |   |

**If no**, explain why the equipment is not available through the TAC Equipment Contractor.

|  |
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# Section 10

## Anticipated maintenance

Consider warranty and suppliers’ recommended service schedule (e.g. requires annual mechanical servicing).

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# Section 11

## Training requirements

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| --- | --- |
| Are there any training requirements? |   |

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

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|   |

# Section 12

## Post-delivery review

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| --- | --- |
| Will you conduct a review of the assistive technology after delivery? |   |

**If no**, please explain why a review is not required.

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|   |

# Section 13

## Follow-up services

**Prescribing occupational therapist follow-up services**

|  |  |  |
| --- | --- | --- |
| Explain why follow-up services or training are recommended | Frequency and duration of follow-up services (e.g. ‘Weekly follow-up for 2 months’) | Comments, including additional travel time  |
|   |   |   |
|   |   |   |
|   |   |   |

**Section 14**

**Additional comments or recommendations**

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|   |

# Section 15

## PROVIDER details

|  |  |
| --- | --- |
| I have discussed with the person and/or representatives and other members of the treating team the information contained in this form, including the requested items, aims, predicted outcomes, maintenance and training requirements.  |   |
|  |

|  |  |
| --- | --- |
| Provider name, address, email and phone number(Type details or insert image of practice stamp) |  |

|  |  |
| --- | --- |
| SWEP credentialing level |   |

|  |  |
| --- | --- |
| Days/hours available |   |

|  |  |
| --- | --- |
| SignatureInsert image (jpg/png) of signature.(Or print, sign and scan the form) |  |



|  |  |
| --- | --- |
| Date |  / /  |

****

**Submitting this form**

Email your completed form to your TAC claims manager or to info@tac.vic.gov.au with the client’s TAC claim number in the subject line. Please also attach any supporting documentation.

### Privacy

The TAC will retain the information provided and may use or disclose it to make further inquiries to 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 the treatment is reasonable and may not be able to approve further benefits and treatment. If you require further information about our privacy policy, please call the TAC on 1300 654 329 or visit our website at [www.tac.vic.gov.au](http://www.tac.vic.gov.au)