Palliative Care Programme Funding Equipment Application

***Incomplete forms or absence of additional information will delay the process. ***

***If this request is URGENT please contact the relevant Palliative Care Service Team direct or via the Hospital switch**

Location of patient

☐ Home / Priv Residence ☐ RBWH ☐ TPCH ☐ Redcliffe / Caboolture / Kilcoy Hospital ☐ Private Hosp ....

Patient information

Family Name Given Name	DOB
Address Perm/Temp	Sex ☐ Female ☐ Male ☐ Indeterminate
Suburb Postcode	Medicare no.
Phone Mobile	Hospital /UR number
DVA no.	Private Health Insurance

NOK/Carer/person to contact re: delivery of Equipment Contacted ☐ Aware of potential delivery costs ☐ Space Cleared ☐

Name Relationship	Phone Mobile
Equipment Delivery address: (if different to client address)	Stairs ☐ Yes ☐ No
Address	Delivery Required Date : ____/____/20
Suburb Postcode	Time : ☐AM ☐PM

Clinician making application / Discharge Facilitator and/or GP details		**Equipment required to be in place by**
Date of referral	☐ GP same as referrer	☐ 24hrs (please call to discuss)
Referrer name	GP name	☐ Discharge Date / / 20
Referrer phone	GP phone	☐ Already Discussed with: ....(Name) Date: / /20
Position/ Designation : Address/Site:	GP address	***Phone calls must be followed up by written application.***
Domiciliary Service Provider ☐ Blue Care ☐ Silver Chain ☐ Other (name)	Known to MNHHS Palliative Care Service ☐ Yes ☐ RBWH ☐ Chermside ☐ Red / Cab ☐ No	SaAS-Palliative-Care@health.qld.gov.au **Fax: 3049 1259 Attn: Palliative Care**

Life limiting Illness

Primary Diagnosis ,Co- morbidities/Symptoms :ie: Dyspnoea/ Pressure Injuries

Equipment Required

☐ Hosp Bed Package ./c pressure mattress & goose neck OR ☐ Electric Recliner Chair	☐ Hoist > Requires OT/ Physio assessment plus completion of specific Hoist Application ☐ Hoist Application attached
Bed centred care ☐ Transfer in/ out bed ☐ Asst ☐ Indep Time in bed % of 24 hrs : ☐100% ☐75% ☐ 50% ☐ 25%	**If not requesting Bed/ Recliner then can request >** ☐ Combined mobile shower chair/ commode (self fund insert) ☐ Wheelchair

Office use only – MNHHS – Palliative Care Service

Funding Approved ☐ Yes Arranged Delivery Date : __/__/20 Time : ☐AM ☐PM

Funding Approved ☐ No ☐ Contact made with referrer suggesting alternative plan : ______________________________

Documentation Complete ☐ Comments: ____

Reviewed by Name: _______________________ Print Name ___________________ Date: __/__/20

Great state. Great opportunity.