



# Equipment Needs Determination Form

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Person Making Referral: \_\_\_\_\_ Service Area and Location: \_\_\_\_\_

Position at Novita: \_\_\_\_\_

## Equipment Type (tick relevant equipment)

### Mobility

- Manual Wheelchair
- Powered Wheelchair
- Walker
- Pusher

### Positioning

- Posture Chair
- Standing Frame
- Sleeping

### ADL Equipment

- Home Modifications
- Preschool/School Modifications
- Shower/Toilet Chair
- Bath Chair
- Hoist
- Sling
- Bed
- Mattress/Overlay

### Communication

- Speech Generating Device
- Low Tech Communication System
- Voice Amplification

### Technology

- Switch Access
- Mouse Access
- Keyboard
- Eye Gaze System
- Portable Note Taker
- Software
- Mounting
- Integrated Control System
- Environmental Control System
- Phone Access

Other (please specify) \_\_\_\_\_ **Equipment Priority Score** \_\_\_\_\_

## Reason for requesting equipment:

Why is the equipment needed, current limitations to participation and function.

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## Specific parameters, key features and dimensions required:

Please be specific as this information will be used to see if anything suitable can be found in stock. Please indicate essential versus preferred parameters. Refer to EON form for multidisciplinary considerations.

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**Need identified by:**

Client                       Carer                       Teacher  
 Parent                       Therapist                       Other \_\_\_\_\_

**Equipment to be used by:**

Client                       Carer                       Teacher  
 Parent                       Therapist                       Other \_\_\_\_\_

**Current equipment:**

\_\_\_\_\_

**Use of current equipment:**

Purpose of equipment, what is working, what is not working, what level of support is required.

\_\_\_\_\_  
\_\_\_\_\_

**Relevant Previous Equipment History:**

What has been trialled in the past, what worked, what didn't work.

\_\_\_\_\_  
\_\_\_\_\_

**Specific tasks equipment is needed for, environments where equipment will be used and possible limitations:**

\_\_\_\_\_  
\_\_\_\_\_

**Options and solutions discussed with family (and family's likely preferred option):**

Please also indicate any options or ideas that have not yet been discussed with the family.

\_\_\_\_\_  
\_\_\_\_\_

**Suggested consultation (people, places, methods):**

\_\_\_\_\_  
\_\_\_\_\_

**Any other important information:**

\_\_\_\_\_  
\_\_\_\_\_

**Approximate cost (refer to cost guidelines):** \_\_\_\_\_

Temporary client file started and labeled                       Initial priority form completed  
 Risk Assessment completed (if applicable)

\_\_\_\_\_  
Signature of Staff Member                      Date