FlexEquip Equipment Referral Form

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FlexEquip is a service provided by the Motor Neurone Disease Association of NSW (MND NSW) to assist people with rapidly progressive neurological conditions (motor neurone disease, multiple sclerosis and muscular dystrophy) get equipment to meet short-term needs. For more information about FlexEquip visit www.flexequip.com.au.

Please view the *FlexEquip Terms and Conditions for motor neurone disease/FlexEquip Terms and Conditions for multiple sclerosis and muscular dystrophy* at www.flexequip.com.au before submitting this form.

Complete all mandatory fields marked with an *

Information about the client	
Title	
First name *	
Last name *	
Street 1 *	
Street 2	
Suburb *	
State *	
Postcode *	
Phone *	
Mobile	
Email	
Preferred communication	◯ Post ◯ Email
Date of birth * (dd/mm/yyyy)	
My client is a member of *	◯ Motor Neurone Disease Association of NSW (MND NSW) ◯ Multiple Sclerosis Australia (MS Australia) ◯ Muscular Dystrophy New South Wales (MDNSW)

Alternative contact person (in case we are unable to contact the client for delivery or retrieval of equipment)	
Title	
First name *	
Last name *	
Street 1 *	
Street 2	
Suburb *	
State *	
Postcode *	
Phone *	
Mobile	
Email	
Relationship to client *	Wife/female partner

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Client name:_____

Information about the referring health professional	
First name *	
Last name *	
Workplace name *	
Work phone *	
Work fax	
Work email *	
Qualification *	◯ Occupational therapist ◯ Physiotherapist ◯ Speech pathologist

Client details	
Does the client have speech difficulties? *	◯ No or minimal speech difficulties ◯ Moderate speech difficulties – words difficult to understand ◯ No speech
The client is able to write with a pen *	◯ Yes ◯ No
The client is taller than 183cm? *	◯ Yes ◯ No
The client weighs over 100kg *	◯ Yes ◯ No
The equipment is required to improve respiratory comfort *	◯ Yes ◯ No
The client lives at home or in low level care * (e.g. hostel, independent unit)	◯ Yes ◯ No

Delivery details	
How many stairs to client's front door? *	◯ 0 ◯ 1 ◯ 2 ◯ More than 2
There is a sealed road to the client's place of residence *	◯ Yes ◯ No

Funding details	
The client is eligible for provision of equipment through EnableNSW *	◯ Yes ◯ No
The client is applying to EnableNSW for these item/s *	◯ Yes ◯ No
The client requires this equipment for short term use *	◯ Yes ◯ No
The client is registered with DisabilityCare (NDIS) *	◯ Yes ◯ No
DisabilityCare join date (dd/mm/yyyy)	
DisabilityCare ref ID	

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Client name:_____

Equipment requested (one item per line where possible)	
Equipment item	*Additional information: size, type*

I, the requesting health professional, agree that:

- ☐ I have assessed the client for the items of equipment listed above
- ☐ I will setup and instruct the person, in their living environment, on the safe use of the equipment
- ☐ no modifications are to be made to any equipment items without prior authorisation from FlexEquip
- ☐ I will prepare and submit ENABLENSW Equipment Request Form if requested to by FlexEquip

and the client,

- ☐ is an adult with rapidly deteriorating/progressive neurological condition
- ☐ is aware of this request for equipment and has consented to health information being passed on to FlexEquip
- ☐ agrees that no modifications are to be made to any equipment items without prior authorisation from FlexEquip
- ☐ has a short-term equipment need that cannot be filled by EnableNSW (in a timely manner or at all)
- ☐ agrees to submit ENABLENSW Consumer Application Form if requested by FlexEquip and also agrees to advise FlexEquip of the outcome of the application

Signed:_____Date:_____
(referring health professional)

Your referral will be acknowledged by email within 3 working days. If you do not receive this email contact flexequip@mndnsw.asn.au