Request for SEMAT Services

Don't like filling in forms or having trouble with this document?

Please call 1300 278 445 and ask to speak to an intake team member who will complete a brief interview by phone.

OFFICE USE ONLY

Job summary: _____ **Job number:** _____

_____

Date received: _____ **Date closed:** _____

Details of the person being referred:

Surname: _____ First Name: _____

Date of Birth: _____ Gender: Male ☐ Female ☐ Other ☐

Email: _____

Address: _____ P/code: _____

Phone: _____ Preferred contact method: Phone ☐ Email ☐

Current Chair:

Manual/Power: _____ Brand: _____

Dimensions: (seat depth / back height / width) _____

Parent/Guardian/Person Responsible details:

Relationship: Self ☐ Parent/Guardian ☐ Spouse ☐ Carer ☐ Other ☐

Name: _____

Email: _____

Address: (if different from above) _____

Phone: _____

Is English the main language spoken at home? Yes ☐ No ☐

If NO, is an interpreter needed? Yes ☐ No ☐

If YES, which language? _____

Is the person aware of the referral? Yes ☐ No ☐

If the referral is for a child, are there any Court Orders or Parenting Orders in place?

Yes ☐ No ☐

If YES, please provide details of the arrangement(s). You will need to provide a copy at the first appointment:

Main reason for referral:

- ☐ Assessment for new equipment
- ☐ Customisation of existing equipment
- ☐ Review of existing equipment
- ☐ Repairs/maintenance to existing equipment

If you are requesting an assessment for a new piece of equipment, what type of equipment do you need?
Eg: power wheelchair, commode etc.

_____

1. Presenting problem:

2. Client seating or equipment goal(s):

Funding being used to access SEMAT services:

- ☐ DHHS/ TasEquip
- ☐ Self Funding/Private
- ☐ MAIB
  (Claim #) _____
- ☐ Other (Please state)
  _____

- ☐ NDIS:
  (Claim #) _____
  Plan expiry date: _____
  Support item number: _____
  Support co-ordinator: _____
  Is your NDIS plan self-managed? Yes ☐ No ☐

WITHIN THE LAST FOUR (4) WEEKS:	Yes	No
1. Has the individual had red areas on their bottom?	2	0
2. Has the individual had an open pressure sore on their bottom?	2	0
3. Has the individual had red areas on their back?	1	0
4. Has the individual had an open pressure sore on their back?	2	0
5. Has the individual reported or demonstrated behaviours that indicate they could be in discomfort or pain while sitting for any length of time? *(such as moaning, grimacing or agitation)*	1	0
6. Has the individual had difficulty propelling their wheelchair? *(If the individual does not propel their wheelchair circle 0)*	1	0
7. Has the individual required repositioning as a result of sliding or leaning?	1	0
8. Has an anti-slide device such as a foam bolster, pommel, posture pal, or posey restraint been used?	1	0
9. Has the individual not been using wheelchair seat cushion? *(Do not include linens, pillows, incontinence pads or home made foam cushions)*	1	0
10. Has the individual tipped their wheelchair or been at risk of tipping their wheelchair?	1	0

Person making the referral (Referring Agent):

Name: _____

Position and Organisation: (if applicable) _____

Address: _____ State: _____ P/code: _____

Email: _____

Phone: _____

Signature of referrer: _____ Date: _____

Return to:
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Launceston TAS 7250

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