Request for EMS Advice and Outcome Summary

## Completed by EMS Assessor

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Person’s Details** | | | |  | | | |  | |
| **Family Name** | | [Family Name] | | **First Name(s)** | | | | [First Name(s)] | |
| **NHI Number** | | [NHI] | | **Date of Birth** | | | | Enter date of birth. | |
| **Address** | | Address. | | **Email Address** | | | | Email Address | |
| **EMS Assessor’s Details** | | | |  | | |  | | |
| **Name** | | Name | | **AEA No.** | | | AEA No. | | |
| **Phone Number** | | Phone. | | | | | | | |
| **Email Address** | | Email Address | | | | | | | |
| **Preferred method of contact:** | | | Choose an item. | | | | | | |
| **Preferred time/day for contact:** | | | Enter time(s) and day(s). | | | | | | |
| **Eligibility Details** | | | |  | | | | |  |
| **Primary Diagnosis:** | | Choose an item | | **Coexisting condition or other:** | | | | | Enter text. |
| **Resides:** | | Choose an item | | **If not listed, please state**: | | | | | Enter text. |
| **Funding Stream:** | | Choose an item | |  | | | | |  |
| **EMS Advice Requested** | | | | | | | | | |
|  | **Mandatory Consultation** | | |  | **Optional Consultation** | | | | |
| **Equipment** | | Choose an item | | **Housing** | | Choose an item | | | |
| **Vehicle** | | Choose an item | |  | |  | | | |

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| --- | --- | --- | --- | --- | --- |
| **Explanation of Situation** | | | | | |
| **Background Information** (e.g., person’s social & living situation, roles, relevant history, services or supports) | | | Click or tap here to enter text. | | |
| **Current Functional Ability**  (e.g., person’s current equipment, strengths, and functional limitations/disability) | | | Click or tap here to enter text. | | |
| **Person’s Goals or Aspirations** | | | Click or tap here to enter text. | | |
| **Clinical Reasoning for your proposed solution** (including alternative options considered) | | | Click or tap here to enter text. | | |
| **Proposed Solution** (list your specific or preferred options if known) | | | Click or tap here to enter text. | | |
| **Include Attachments (where applicable)** | | | | | |
| * **Existing & proposed modification sketch (include measurements)** * **Equipment quote** * **Manual or Powerchair specification form** * **Photos or video** | | | | | * **Confirmation of LTS-CHC funding** * **Evidence of main carer** * **Evidence of full-time tertiary study** * **Evidence of voluntary work** * **Evidence of full-time employment** |
| **Outcome of Consultation – Completed by Clinical Services Advisor** | | | | | |
| **Consultation Notes/Advice** | | | | Click or tap here to enter text. | |
| **Previous Funding History** | | | | Click or tap here to enter text. | |
| **Consultation Outcome** | | | | Click or tap here to enter text. | |
|  | **Solution meets Disability Support Services (DSS) access criteria, proceed to the DSS|EMS Portal.** | | | | |
|  | **Solution does not meet DSS access criteria, consider an alternative solution.** | | | | |
|  | **Other** | Enter text. | | | |
| **Date Completed** | | | | | Enter a date |
| **Clinical Services Advisor** | | | | | Choose an item |
| **Designation** | | | | | Choose an item |
| Click on the icon below to paste in any photos (not related to a housing modification) | | | | | |

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