Request for EMS Advice and Outcome Summary

## Completed by EMS Assessor

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| **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**
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| **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) |

  

  

   