State-wide Equipment Program - Continence Aids
Request for Additional Products

Consumer Name: _____ Consumer D.O.B: _____

Product Request:

Category

Description

Manufacturer Code

Supplier Code

Clinical Justification:

Is an alternative product available in the current list? Yes ☐ / No ☐

If yes, please provide details explaining why you are unable to prescribe the product.

Practitioner Name: _____Practitioner Registration Number: _____

Practitioner Contact Phone Number: _____

Signed: _____ Date: _____

© 2017

State-wide Equipment Program - Continence Aids
Request for Additional Products

Practitioners will be notified of the outcome once the decision has been made.

SWEP use only

Date: _____

Clinical Advisor completing assessment:

_____

Approved: Yes ☐ / No ☐

Explanation of outcome:

Practitioner notified of outcome: (Date) _____

© 2017