**Review Request Form**

**This form may be submitted to request a review of the priority of a waitlisted application lodged with SWEP. You may also submit this form for a review of an application that has been declined by SWEP.You will receive a response within 10 working days.**

*Please refer to the relevant guidelines and prescriber manuals when completing this form.*

*Do not request review of Aids & Equipment which are not included in the SWEP Picklists & Catalogue or the VA&EP Guidelines.*

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| Client Information |
| **SWEP Client ID Number: (If Known)** Click here to enter text. |
| **First Name:** Click here to enter text.**Surname:** Click here to enter text. | **Full Address, Suburb and Postcode:**Click here to enter text. |
| **Date of birth:** Click here to enter a date. |
| **Phone** | Click here to enter text. | **Mobile** | Click here to enter text. |
| Application Details |
| **SWEP Application Number (If Known)** Click here to enter text. |
| **Application Item/s for review:**Click here to enter text. | **Date of original Application:**Click here to enter a date. | **Are you the original prescriber? Yes**[ ]  **No**[ ]  |
| **If not, provide original prescriber’s name:**Click here to enter text. |
| **Review Request Type** |
| [ ]  **Review for Escalation**Go to Section 1 | [ ]  **Review of Declined Application**Go to Section 2 |
| **Section 1: Review of Priority of Waitlisted Application** |
| **Provide any additional relevant information regarding the client’s condition or situation which was not included in the initial application.***Example: Change in need, characteristics, carer or home situation, equipment trials or hire, new diagnosis, assessment, or risk of injury.*Click here to enter text. |
| **What other equipment, measures or strategies have been implemented or examined to reduce the risks to the client &/or carer?** Click here to enter text. |
| I confirm that tendered and reissue equipment has been examined for suitability [ ]  N/A [ ] Please provide clinical rationale if tender or reissue equipment is not suitable: Click here to enter text. |
| **Have any of the Implications of Non-Provision Changed?** |
| **Yes** [ ]  **No** [ ] If yes complete the following sections. |
| **Outline the threat to the safety of your client: N/A** [ ] Click here to enter text. |
| **When will this occur:**[ ] Imminent (Has already occurred or expected to occur in next 1 months)[ ] Likely (Likely to occur in next 1-4 months)[ ]  Possible(Likely to occur in next 4-12 months) |
| **Outline the threat to the independence of your client: N/A** [ ] Click here to enter text. |
| **When will this occur:**[ ]  Imminent (Has already occurred or expected to occur in next 1 months)[ ]  Likely (Likely to occur in next 1-4 months)[ ]  Possible(Likely to occur in next 4-12 months) |
| **Outline which aspects of the client’s health would deteriorate and why? N/A** [ ] Click here to enter text. |
| **When will this occur:**[ ]  Imminent (Has already occurred or expected to occur in next 1 months)[ ]  Likely (Likely to occur in next 1-4 months)[ ]  Possible(Likely to occur in next 4-12 months) |
| **Section 2: Review of Declined Application**  |
| **Provide any additional relevant information regarding the client’s condition or situation which was not included in the initial application.***Example: Change in need, characteristics, carer or home situation, equipment trials or hire, new diagnosis, or assessment.*Click here to enter text. |
| **Declaration** **(Mandatory – only submit review requests where this declaration is made)** |
| [ ]  I confirm that the client or primary carer is aware of this request and is in agreement[ ]  I understand that all the information that I have supplied on this request is true and correct. |
| **Name of person completing form:** Click here to enter text.**Relationship to client / carer:** Click here to enter text.**Date:** Click here to enter a date. | **Name of Prescribing Organisation:** Click here to enter text.**N/A** [ ] **Phone:** Click here to enter text.**Email:** Click here to enter text. |
| **Please send the completed document to** **swepcentralintake@bhs.org.au** |
| **Office Use Only** |
| **Received Date:** Click here to enter a date.**Decision:** [ ]  **Maintain Status** [ ]  **Alter Status** **Reason:** Click here to enter text.[ ]  **Notification Sent** **Administration Officer:** Click here to enter text. |