**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**](mailto: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. | | | | | | | |