Domiciliary Equipment Service

Government of South Australia
Department for Communities and Social Inclusion

ACH Group

Equipment Prescription Form

ACH PROGRAM

TCP (AOA00327) ☐ CDC CACP - LEVEL 1 (AOA00335) ☐ CDC CACP - LEVEL 2 (AOA00335) ☐
STRC (C008231) ☐ CDC EACH - LEVEL 3 (AOA00336) ☐ CDC EACH - LEVEL 4 (AOA00336) ☐
OTHER ☐ (*Please specify*).....

ACH REGION (FOR ACH USE ONLY)

EAST ☐ NORTH ☐ WEST ☐ INNER SOUTH ☐ STH (Christie Downs) ☐
STH (Fleurieu) ☐ STH (Murray Bridge/Murray Mallee) ☐ STH (Mannum/Riverland) ☐

CLIENT DETAILS

CIM Client Number:	Comcare Number:
Client Surname:	Client First Name:
Date of Birth:	M ☐ F ☐ Other ☐
Usual Address: No. Street:	
Suburb: Post Code: Phone Number:	
Weight Kgs: <90☐ >90☐ >110☐ >120☐ >130☐ >150☐ >170☐ >190☐ >210☐	

SPECIAL INSTRUCTIONS AND ITEM DETAILS

DELIVERY ADDRESS (WRITE "AS ABOVE" IF SAME AS USUAL ADDRESS)

CONTACT PERSON:

INSTRUCTIONS: SPECIAL NEEDS; DELIVERY INSTRUCTIONS; INSTALLATION HEIGHTS, LOCATIONS, ETC

SAFETY PRECAUTIONS/ALERTS: MUST NOT BE LEFT BLANK; WRITE 'NIL' IF NO INFORMATION

DELIVERY TIMEFRAME: STANDARD/HIGH ☐ URGENT ☐ IMMEDIATE ☐
(URGENT/IMMEDIATE DELIVERIES INCUR EXTRA DELIVERY CHARGES)

PREFERRED DELIVERY TIME: AM ☐ PM ☐ ANY ☐

ITEM NO	QTY	EQUIPMENT DESCRIPTION (AS PER CATALOGUE)	REPLACEMENT ITEM?	SUBSTITUTE PERMITTED?

PERSON COMPLETING FORM:	**PHONE NUMBER:**
PRESCRIBER NAME/S (IF NOT AS ABOVE):	
EMAIL/S:	**PHONE NUMBER:**
ACH PRESCRIBER? OT ☐ PT ☐ RN ☐ ADVISOR/EN ☐ (TICK MORE THAN ONE IF JOINT AX)	**DATE:**
ACH USE ONLY: REQUIRES TM APPROVAL? IF Y NAME:	**SIGN:**
ACH OFFICE USE ONLY Order Reviewed:	**Recommendations/Followup:**
SIGN: **PRINT NAME:**	**DATE:**

ACH to email completed form to: SUBMIT TO DES EMAIL **or Fax to: 1300 295 839**