



**Equipment Services
Urgent Processing Justification**

0210

(To be submitted with all MASS 20 applications where urgent processing is justified)

Applicant's Full Name: _____

DOB: _____

To be completed by a MASS Designated Prescriber in accordance with the MASS Statewide Prescriber Procedure Manual. If urgent processing is being requested, please complete this form and attach to the front of the MASS 20 application form.

REASON FOR REQUEST FOR URGENT PROCESSING – <u>Client must meet one of the seven specified criteria, then provide all details for that criteria. Complete others if applicable or to clarify need for multiple items.</u>	
<input type="checkbox"/> 1. Hospital Discharge <i>(Please fully complete this section to justify <u>Hospital Discharge</u> request for consideration)</i>	<input type="checkbox"/> Name of Hospital <input type="checkbox"/> Date of Discharge <input type="checkbox"/> Unable to discharge client without requested equipment <input type="checkbox"/> Unable to source equipment elsewhere <input type="checkbox"/> Specify equipment on application required prior to hospital discharge (if more than 1 item requested) <input type="checkbox"/> Equipment has been sourced and is available for discharge date (eg supplier, MASS stock). Comment
<input type="checkbox"/> 2. Risk of imminent hospitalisation <i>(Please fully complete this section to justify <u>Risk of imminent hospitalisation</u> request for consideration)</i>	<input type="checkbox"/> Client requires equipment to prevent hospital admission due to safety concerns or medical need. Specify equipment (if more than 1) Provide reasons <input type="checkbox"/> Supporting documentation attached (required) (please list)
<input type="checkbox"/> 3. Modifications &/or accessories to MASS equipment - client is at risk because of that equipment <i>(Please fully complete this section to justify <u>client at risk because of equipment</u> request for consideration)</i>	Specify equipment MASS Plaque Number Reason equipment is unsafe and modification required

MEDICAL AIDS SUBSIDY SCHEME (MASS)

Applicant's Full Name: _____

DOB: _____

<input type="checkbox"/> 4. Replacement of equipment unsafe for use <i>(Please fully complete this section to justify <u>Replacement of equipment unsafe for use</u> request for consideration)</i>	Specify equipment MASS Plaque Number (if applicable) Reason equipment is unsafe <input type="checkbox"/> Supporting documentation attached if relevant (please list)
<input type="checkbox"/> 5. Pressure Redistribution Equipment <i>(Please fully complete this section to justify <u>Pressure Redistribution Equipment</u> request for consideration)</i>	<input type="checkbox"/> Pressure Redistribution Cushion/ mattress/ seat or cushion for mobile overtoilet showerchair <input type="checkbox"/> Supporting documentation attached (required) (please list)
<input type="checkbox"/> 6. Falls Risk <i>(Please fully complete this section to justify <u>Falls Risk</u> request for consideration)</i>	<input type="checkbox"/> Client has history of falls and a diagnosis of osteoporosis and/or <input type="checkbox"/> High Falls risk <input type="checkbox"/> Risk assessment attached (required) – include number of risk factors <input type="checkbox"/> Requested equipment will assist to minimise falls risk. Comment
<input type="checkbox"/> 7. Carer Strain/Injury <i>(Please fully complete this section to justify <u>Carer Strain / Injury</u> request for consideration)</i>	<input type="checkbox"/> Equipment is required for carer to sustain the carer role. Specify equipment (if more than 1) Provide reasons <input type="checkbox"/> Supporting documentation attached (required) (please list)

I certify that the information contained in this form is in accordance with the MASS Statewide Prescriber Procedures Manual			
Name		Profession	
Signature		Date	
Telephone		Fax	