# RAP Item Prior Approval Template

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| **Assessing health provider’s Details** |
| Date of Assessment |  / /20 |
| Organisation |  |
| Prescriber Name |  |
| Prescriber Number |  |
| Qualification(s) |  |
| Address 1 |  |
| Address 2 |  |
| City/Suburb |  |
| State/Territory |  | Phone | ( ) |
| Postcode |  | Fax | ( ) |
| email |  |

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| **Entitled person’s Details** |
| Entitled person’s Name |  |
| DVA File Number |  |
| Address 1 |  |
| Address 2 |  |
| City/Suburb |  |
| State/Territory |  |
| Postcode |  | Phone | ( ) |
| Repatriation Health Card Type | 🞎 Gold Card 🞎 White Card |

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| **Entitled person’s Medical History** |
| Vision-related diagnosis |  |
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| Non-Vision-related diagnosis |  |
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| Visual Acuity (corrected) | Distance: Near: |
| Field Defects |  |

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| **Entitled person’s Functional Status** |
| Physical function, including mobility and details of any equipment used |  |
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| Upper limb function |  |
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| Cognitive function and competence to operate a device |  |
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| **Entitled person’s Social Situation** |
| The entitled person lives: | 🞎 alone🞎 with a partner🞎 other |
| Ability of partner/carer to carry out the tasks for which the device is being requested,e.g. reading |  |
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| **Assessment Results** |
| Provide details of alternative equipment trialled and the results |  |
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| Devices trialled and results |  |
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| **Recommendation** |
| Full details (make, model and any necessary accessories) of equipment recommended, and the approximate cost.Justify your recommendation. |  |
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|  |
| Prescriber’s signature |  |
| Date |  / /20 |