# 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 |