|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Notes for AT Assessors of Continence AT Supports | | | | | | | | | | | | | | | | | | | | | |
| **There are specific templates available for the following types of AT:**   * General Assistive Technology Assessment * Continence Assessment * Prosthetics and Orthotics Assessment * Vehicle Modifications Assessment * Complex Home Modification Assessment * Dog Guide Assessment   The assessment information provided in this form will be used by the NDIA to understand how the specified AT will assist the participant to pursue their goals and to assess whether it is reasonable and necessary for the NDIS to fund AT support.  Using this template is not mandatory. If a provider elects to provide information in another format, they must include all information described in this template. Information provided needs to include an outline of the functional impact of each feature being recommended. This should include how the AT will support capacity building, promote independence and impact alternative forms of support.  The primary criteria NDIS delegates use when determining if a piece of equipment or modification is suitable for the NDIS to fund is section 34: reasonable and necessary supports of the [National Disability Insurance Scheme Act 2013 (NDIS Act; external) and section 34.](https://www.legislation.gov.au/Latest/C2018C00276)  Additional information on how the recommendation(s) will be considered in the context of specific supports can be found in the NDIS Operational Guidelines available online and the [NDIS (Supports for Participants) Rules 2013](https://www.legislation.gov.au/Details/F2013L01063).  **AT Strategy:** Supports will be provided in line with the NDIA’s AT Strategy that can be found at [Assistive Technology Strategy](https://www.ndis.gov.au/about-us/strategies/assistive-technology-strategy) and as outlined in [NDIS AT Complexity](https://www.ndis.gov.au/providers/essentials-providers-working-ndia/providing-assistive-technologies-and-home-modifications) document.  **Assistive Technology (AT) Assessor:** An AT assessor is able to assess a participant's needs and situation and identify the most appropriate AT, they may be an AT Mentor, allied health practitioner, continence nurse, rehabilitation engineer or other suitably qualified practitioner.  AT Assessors have obligations under the NDIS Provider Terms of Business, Quality and Safeguards Commission and their respective professional registration under Australian Health Practitioner Regulation Agency (AHPRA).  **Caution:** AT Assessors must be aware of and observe the law with regard to AT that is likely to restrain a participant. [National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018](https://www.legislation.gov.au/Details/F2018L00632)  The NDIA expects AT assessors to consider all options for addressing the participant’s disability related functional limitations and pursuing goals, including non-AT supports.  **NDIS AT Levels 3 & 4 trials:** Where the AT assessor and participant need to work with an AT supplier to trial and develop a specification for the AT support, reasonable supplier costs can be quoted, and if agreed, claimed against the participant’s plan (category ‘rental/trial’). Supplier specification/order details are required with this assessment to enable the NDIS to consider quotes/prices from the supplier.  Quotations should be attached where applicable (items < $1500 may be funded from the CORE consumables budget and do not require an assessment and quote). Quotations can include printouts of web orders and stock numbers from relevant State based equipment suppliers where relevant.  AT assessors can keep up to date at [NDIS provider assistive technology.](https://www.ndis.gov.au/providers/essentials-providers-working-ndia/providing-assistive-technologies-and-home-modifications) Participants can keep up to date at [NDIS participant assistive technology.](https://www.ndis.gov.au/participants/home-equipment-and-supports) | | | | | | | | | | | | | | | | | | | | | |
| Notes for navigating and editing this document | | | | | | | | | | | | | | | | | | | | | |
| General Notes This document is protected so that only editable fields can be changed but additional rows in tables can be inserted as required.  All editable fields have unlimited text entry, and the document will expand in page length when large amounts of text are entered.  Spelling and grammar can be checked according to the word processor you are using.  The document can be navigated with just the Tab key to encompass varying modes of navigation and levels of computer skills JAWS Specific Comments Ins + F1 will read document information including the general layout, header and footer information  Ins + F6 will bring up a headings list allowing a JAWS user to jump to heading sections if desired  Ins + F7 will bring a list of web links embedded in the document.  Ins + Z will turn on quick navigation fields so a JAWS user can use say “H” to jump to the next heading for easy navigation. | | | | | | | | | | | | | | | | | | | | | |
| PART 1 – Participant and Plan Management Details | | | | | | | | | | | | | | | | | | | | | |
| 1.1 NDIS Participant Details | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | |  | | | | | | | | | | | | | | | | |
| Date of Birth | | | | |  | | | | | | | | | | | | | | | | |
| Age | | | | |  | | | | | | | | | | | | | | | | |
| NDIS Number | | | | |  | | | | | | | | | | | | | | | | |
| Address | | | | |  | | | | | | | | | | | | | | | | |
| Contact Telephone Number | | | | |  | | | | | | | | | | | | | | | | |
| Email | | | | |  | | | | | | | | | | | | | | | | |
| Preferred Contact Method | | | | |  | | | | | | | | | | | | | | | | |
| Nominee or Guardian Name | | | | |  | | | | | | | | | | | | | | | | |
| Nominee or Guardian Phone | | | | |  | | | | | | | | | | | | | | | | |
| NDIS Support Coordinator | | | | |  | | | | | | | | | | | | | | | | |
| Contact Details | | | | |  | | | | | | | | | | | | | | | | |
| 1.2 Plan Management Details | | | | | | | | | | | | | | | | | | | | | |
| Agency Managed | | | | | | | | | |  | | | | | | | | | | | |
| Self-Managed | | | | | | | | | |  | | | | | | | | | | | |
| Registered Plan Management Provider | | | | | | | | | |  | | | | | | | | | | | |
| Contact Details | | | | | | | | | |  | | | | | | | | | | | |
| PART 2 – Assessment | | | | | | | | | | | | | | | | | | | | | |
| 2.1 Background | | | | | | | | | | | | | | | | | | | | | |
| General: Describe participant’s current status which may include diagnosis, prognosis, co-existing conditions, disability, personal and instrumental activities of daily living, formal and informal support arrangements and life transitions. Consider health issues and other related aspects that may influence the need for continence support. | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| 2.2 Participant Goals | | | | | | | | | | | | | | | | | | | | | |
| If the participant’s NDIS plan has been made available, you can refer to the statement of participant’s goals and outline those relevant to the AT solution. | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| 2.3 Functional Assessment | | | | | | | | | | | | | | | | | | | | | |
| Note current level of function related to disability and impact on life roles: skin integrity issues; rapidly changing condition – including cognitive issues; dexterity and mobility issues. Consider the need for a support person to assist with the use of continence products. Does the participant currently need assistance to use their continence items? What assistance do they currently get? Will your recommendations result in a change in personal care needs? What assistance will the participant need?  NDIS expects relevant assessments are conducted where required and records held by AT assessor for NDIS audit purposes. | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Indicate type of loss | | | | | | | | | | | | | | | | | | | | | |
| Bladder | | | |  | | | | | | | | | | | | | | | | | |
| Bowel | | | |  | | | | | | | | | | | | | | | | | |
| 2.4 Current Continence products in use | | | | | | | | | | | | | | | | | | | | | |
| Type of Continence Product | | | Usage | | | | | | | | | Participant’s report of suitability | | | | | Does it need reassessment  Yes/No | | | | |
|  | | |  | | | | | | | | |  | | | | |  | | | | |
|  | | |  | | | | | | | | |  | | | | |  | | | | |
| 2.5 Consideration of health and other issues | | | | | | | | | | | | | | | | | | | | | |
| 2.5.1 Summarise recommendations from allied health and/or medical assessments. | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| 2.5.2 Are further health, medical assessments, AT solutions and/or advice required from any of the following health or allied health professionals? Yes/No | | | | | | | | | | | | | | | | | | | | |  |
| Indicate relevant health professional | | | | | | | | | | | | | | | | | | | | | |
| Physiotherapist | | | | | | | | | | |  | | | | | | | | | | |
| Dietician | | | | | | | | | | |  | | | | | | | | | | |
| Occupational Therapist | | | | | | | | | | |  | | | | | | | | | | |
| Psychologist | | | | | | | | | | |  | | | | | | | | | | |
| General Practitioner | | | | | | | | | | |  | | | | | | | | | | |
| Medical Specialist | | | | | | | | | | |  | | | | | | | | | | |
| Other | | | | | | | | | | |  | | | | | | | | | | |
| If yes, please provide the following information   * Has the participant agreed to seek this assessment and/or advice? * Is the participant aware that the NDIS cannot fund mainstream medical and health services? * Describe the additional continence product/training needs identified by participant/Continence Assessor? * Are other AT solutions or environmental adaptations/home modifications such as toileting AT or bathroom modifications required[[1]](#footnote-1)? * Does the participant demonstrate behaviours of concern and have a behaviour support plan for restrictive practice? * How might the outcome of this advice change the recommended NDIS continence supports to pursue the participant’s goals? | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| PART 3 - Exploration of Continence Interventions and Options | | | | | | | | | | | | | | | | | | | | | |
| 3.1 Evaluation of options | | | | | | | | | | | | | | | | | | | | | |
| Thorough list of alternatives including use of other supports and approaches. Where trials have been conducted please give details of where the trials took place and for how long. NOTE training in device use is included and expected to be accomplished within 2 hours. Provide rationale and hours required if more extensive or specific training is indicated. | | | | | | | | | | | | | | | | | | | | | |
| Option | Describe potential options trialled in relation to goal attainment | | | | | Trialled (T) or Considered (C)? Include trial details (timing, location) | | | | | | | | Advantages | Disadvantages | | | | Estimated hours for training & review | | |
|  |  | | | | |  | | | | | | | |  |  | | | |  | | |
|  |  | | | | |  | | | | | | | |  |  | | | |  | | |
|  |  | | | | |  | | | | | | | |  |  | | | |  | | |
|  |  | | | | |  | | | | | | | |  |  | | | |  | | |
| PART 4 – Continence Recommendations | | | | | | | | | | | | | | | | | | | | | |
| 4.1 Provide specific evidence that the supports/products described will enable the participant to pursue their identified goals and be of long-term benefit considering both current and future needs. | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| 4.2 Are there additional features, customisation or specification recommended that is considered to be above the minimum or standard level for this support? Please provide the specific evidence or clinical justification for these. | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| 4.3 Description of continence products and/or AT solution. Detail all necessary components required to meet participant’s goal. This must be detailed enough to ensure that the item can be accurately supplied (attach completed supplier(s) specification/quotes as required). | | | | | | | | | | | | | | | | | | | | | |
| Item | | Quantity | | | | | | Frequency of supply required. (not usually more frequent than quarterly) | | | | | | | | State/territory specification/item ID | | | | | |
|  | |  | | | | | |  | | | | | | | |  | | | | | |
|  | |  | | | | | |  | | | | | | | |  | | | | | |
|  | |  | | | | | |  | | | | | | | |  | | | | | |
| Participant’s preferred supplier (optional): | | | | | | | | | | | | | | | | | |  | | | |
| Is recommendation in line with supplier product use guidance? Yes/No | | | | | | | | | | | | | | | | | |  | | | |
| 4.4 The participant is to be provided with product information and instructions for use including any precautions. Specify who is to do this and when. | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| 4.5 Is urgent supply required? Yes/No Details | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **4.6** Continence product order detail is attached (as advised by supplier(s)) | | | | | | | | | | | | | | | | | | | | | |
| State/Territory Scheme specification (optional) | | | | | | | | | | | | | | | |  | | | | | |
| Other supplier’s specification (optional) | | | | | | | | | | | | | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **4.7** Participant Agreement | | | | | | | | | | | | | | | | | | | | | |
| Does the participant agree with the recommended continence assessment and products? (Are the assessor’s clinical recommendations and participant preference the same?) | | | | | | | | | | | | | | | | | | | | | |
| Yes | | | | | | | | | | | | |  | | | | | | | | |
| No | | | | | | | | | | | | |  | | | | | | | | |
| Please provide details | | | | | | | | | | | | |  | | | | | | | | |
| PART 5 – Details of Assistive Technology Assessor | | | | | | | | | | | | | | | | | | | | | |
| **DECLARATION** (indicate all relevant sections that apply) | | | | | | | | | | | | | | | | | | | | | |
| I certify that I meet the NDIA expectations of AT assessor provider suitability (including understanding of the current NDIS Act, Rules and Operational Guidelines) to assess the type of assistive technology and associated supports, at the level of complexity required by this participant. | | | | | | | | | | | | | | | | | | | |  | |
| I will provide appropriate evidence to the NDIA and/or Quality and Safe Guards Commission if and as requested. | | | | | | | | | | | | | | | | | | | |  | |
| I understand and acknowledge that the NDIA and participant will rely on my professional advice to select, source and implement this assistive technology. | | | | | | | | | | | | | | | | | | | |  | |
| This assistive technology has been assessed by the treating multi-disciplinary team and I have completed the AT assessment on behalf of that team. | | | | | | | | | | | | | | | | | | | |  | |
| **Assessor’s Details** | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | |  | | | | | | | | | | | | | | |
| NDIS Provider Registration number (where applicable) | | | | | | |  | | | | | | | | | | | | | | |
| Phone | | | | | | |  | | | | | | | | | | | | | | |
| Email | | | | | | |  | | | | | | | | | | | | | | |
| Signature | | | | | | |  | | | | | | | | | | | | | | |
| Qualification | | | | | | |  | | | | | | | | | | | | | | |
| Date of Assessment | | | | | | |  | | | | | | | | | | | | | | |
| Date of Report | | | | | | |  | | | | | | | | | | | | | | |
| PART 6 – Consent to Collect and Share Your Information – Provider AT Assessment and Quotation(s) | | | | | | | | | | | | | | | | | | | | | |
| **For the participant to complete**  As a participant who requires assistive technology supports, the National Disability Insurance Agency (NDIA) may need to contact your AT assessor and / or AT supplier to discuss information within your assistive technology assessment and quotation(s). This will assist the NDIA with determining whether your request for assistive technology support(s) can be provided to you under the NDIS. Do you consent to the NDIA collecting and disclosing your information including from these third parties mentioned above, in relation to your assistive technology assessment and quotation? | | | | | | | | | | | | | | | | | | | | | |
| Yes, I consent | | | | | | | | |  | | | | | | | | | | | | |
| No, I do not consent | | | | | | | | |  | | | | | | | | | | | | |
| Participant’s Signature | | | | | | | | |  | | | | | | | | | | | | |
| I understand that I am giving consent to the NDIA to do the things with my information set out in this section. I understand that I can withdraw my consent for the NDIS to do things with my information at any time by letting the NDIA know. | | | | | | | | | | | | | | | | | | | |  | |
| I understand that I can access the NDIA’s Privacy Notice and Privacy Policy on the [NDIA website](https://www.ndis.gov.au/providers/providing-at.html) or by contacting the NDIA. | | | | | | | | | | | | | | | | | | | |  | |
| Signature | | | | | | | | |  | | | | | | | | | | | | |
| Date | | | | | | | | |  | | | | | | | | | | | | |
| Full name | | | | | | | | |  | | | | | | | | | | | | |
| **If you have signed this Form on behalf of the NDIS participant**, please complete the details below. It is an offence to provide false or misleading information.  We may require you to provide evidence of your authority to sign on behalf of the person. | | | | | | | | | | | | | | | | | | | | | |
| Signature | | | | | | | | |  | | | | | | | | | | | | |
| Date | | | | | | | | |  | | | | | | | | | | | | |
| Full Name of person completing this form (please print): | | | | | | | | |  | | | | | | | | | | | | |
| Relationship to participant or person wishing to become an NDIS participant: | | | | | | | | |  | | | | | | | | | | | | |

1. If a bathroom modification is identified refer to the Complex Home Modification Template. [↑](#footnote-ref-1)