# NON-CONTRACT EQUIPMENT RECOMMENDATIONS OVER £500

Service User Details

Name: D.O.B:

Address: Weight & height:
(if applicable for equipment requested)

- *Use as much space as required, the form will expand to meet your needs*
- *All requests for new equipment must be accompanied by a quotation*

| |
|---|
| Date: |
| Form completed by :<br>SS worker involved if different from above:<br>Contact details including email address: |
| Authorisation :<br>Who will be the authorising agency/team<br><br>Is the person funded by Continuing Health Care? |
| Diagnosis/Disability : |
| Assessed Need : |
| Detail Options Considered (what has been looked at e.g. suppliers contacted and quotes received, reasons behind selected choice) : |
| Is it available in refurb? |
| Additional supporting information e.g. expected length of use, relevant previous equipment history : |

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|---|
| Consultation : |
| Equipment Recommended: |
| Cost: £ FACS Banding |
| Benefit of provision (include reason for specific choice): |
| Effect of non-provision: |
| Date:<br>Panel decision / comment space: |