



Electric Mobility Aid Part 1 Medical Information Form

Complete this form for requesting:

- Mobility Scooter
- Electric Wheelchairs
- Power Assist Devices
- Carer-operated Wheelchair.

This form is to be completed by the client's General Practitioner (GP)/LMO.

The provision of electric wheelchairs, mobility scooters and power assist devices does not extend to war widows or dependants. Eligibility for carer operated wheelchair power packs is open to eligible war widows and dependants.

Please refer to the [Rehabilitation Appliances Program - National Guideline Electric Mobility Aids](#)

Provider Hotline: **1800 550 457** – choose Option 1 for Aids & Appliances provided under the Rehabilitation Appliances Program (RAP).

Your personal information is protected by law, including the *Privacy Act 1988*. Your personal information may be collected by the Department of Veterans' Affairs (DVA) for the delivery of government programs for war veterans, members of the Australian Defence Force, members of the Australian Federal Police and their dependants. [Read more: How DVA manages personal information](#)

No duplication of government funded services

It is the responsibility of the requesting health provider to check the client is not accessing the same service/aid/appliance or home modification through more than one government service e.g. National Disability Insurance Scheme (NDIS) and RAP.

GP/LMO's details

Provider Stamp (if applicable)	Name	<input style="width: 95%;" type="text"/>
	Provider number	<input style="width: 60%;" type="text"/>
	Practice address	<input style="width: 95%;" type="text"/>
		POSTCODE <input style="width: 100px;" type="text"/>
	Phone number	[<input style="width: 50px;" type="text"/>] <input style="width: 100px;" type="text"/>
	Fax	[<input style="width: 50px;" type="text"/>] <input style="width: 100px;" type="text"/>
	E-mail	<input style="width: 95%;" type="text"/>

Client details

Surname	<input style="width: 95%;" type="text"/>	
Given name(s)	<input style="width: 95%;" type="text"/>	
Date of birth	<input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	DVA file number <input style="width: 150px;" type="text"/>
Card type	<input type="checkbox"/> Gold <input type="checkbox"/> White - please contact DVA on 1800 550 457 or RAPGeneralEnquiries@dva.gov.au to check eligibility under the client's Accepted Disability(ies).	
Address	<input style="width: 95%;" type="text"/>	
	POSTCODE <input style="width: 100px;" type="text"/>	

NOTE: For White Card holders, the client's eligibility for an electric mobility aid must be established by DVA as a reduction of functional mobility resulting from an Accepted Disability (AD), war related/service illness or injury **before proceeding** with OT assessment.

Surname

DVA File number

Client details continued

Home phone number

Mobile (if known)

Type of request (tick one box only)

- Mobility Scooter Electric Wheelchair
- Power Assist Device Carer-operated Wheelchair Power Pack

Does the client live in a Residential Aged Care Facility (RACF)?

- No Yes - ACFI Classification not yet assigned

ACFI Classification

Does the ACFI classification contain 1 high domain or 2 or more medium domain categories?

- No Yes - Refer to DVA

Note: Please check the [Aged Care Eligibility Matrix](#) as some items should be supplied by the RACF.

Medical Assessment of Safe Usage

Clinical conditions

Please describe all the clinical conditions that affect this client's ability to mobilise, in order of effect.

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Vision

Best Corrected Visual Acuity R

Best Corrected Visual Acuity L

Field of Vision Normal Abnormal - Please give details

Is the veteran colourblind? No Yes

Any current eye conditions e.g. ARMD/Glaucoma? No Yes

Please give details

Is an assessment by an Ophthalmologist required? No Yes

Please attach a copy of recent Ophthalmologist letters, if applicable

Surname

DVA File number

Safe usage

As electric mobility aids are used for mobility on public thoroughfares and roadways, the client's ability to use the vehicle in a safe manner is very important, as they are personally liable for any damage they may cause.

Please list any conditions or personal behaviours including any cognitive decline/impairment or medical conditions (e.g. use of alcohol and/or medications including medicinal cannabis containing THC) which may affect their ability to use the electric mobility aid safely, or react in an emergency situation.

Prognosis

In your opinion is this client's mental, visual and/or physical status likely to deteriorate in the near future and thus render them unable to use the equipment?

- No
- Yes - Please give details

Driving a motor vehicle

Does the client hold a current driver's license?

- No
- Yes

If no, has the client been suspended from driving or ceased driving due to medical reasons?

- No
- Yes

Please give details

Carer details

Relationship

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Age

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Health status

Surname

DVA File number

Additional comments

Please provide any additional comments you think may be relevant to this decision

GP/LMO's recommendation

Do you recommend the provision of an Electric Mobility Aid to this client?

No Yes

GP/LMO's name (Please PRINT)

Phone number

Signature

Date

Please submit this completed form to DVA at the address shown below. Please do not refer this request to an OT until DVA advises that the client meets the criteria for further assessment.

Please return completed forms to the Department, via email (preferred):

RAPGeneralEnquiries@dva.gov.au

OR post to:

**Department of Veterans' Affairs
GPO Box 9998, Brisbane QLD 4001**