# OT & Sensory Unit

# Clinical reasoning for Equipment and Minor Adaptation Panel

**Service user:**

**AIS no: (if known):**

**Address:**

**Tenure:**

**Tel no:**

**Date of birth:**

|  |
| --- |
| Diagnosis – functional abilities – transfers: |
| Social / care issues: |
| Options tried /excluded with reasoning: |
| Immediate needs and risks: |
| **Equipment requested:** |
| **Cost:**  (if known) |

**Referring officer:**

**(sign – print – designation)**

**Address:**

**Contact Telephone No.**

**Date:**

**Approved by OT/OTA’s supervisor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(sign – print – designation)**

**FOR CDS PANEL USE ONLY:**

|  |  |
| --- | --- |
| **Reasons and details if Delegated Authority action is required:** |  |

|  |  |
| --- | --- |
| **Outcome of the Panel:** |  |

|  |  |
| --- | --- |
| **Feedback from Panel:** |  |

|  |  |
| --- | --- |
| **Signature on behalf of Panel:** | **Date:** |