Special Needs Car Restraint from FAS

Recaro

Columbia #2000

Columbia #2500

Columbia #2400

Starlight SP

Sonja

Otto Bock Lars

FAS Buckle Guard

Transport Supporter

E-Z-On Vest

ORDERING PROCEDURE FOR FAS CAR RESTRAINTS

1. Please ring us on 03-95876766, or 1300 303 536, or 02-96494044, or download from www.fasequipment.com the Special Needs Car Restraint Information, and the Order and Prescription Form.
2. The prescriber (therapist or health professional) should follow the "guidelines for the prescriber" and discuss with parent, carer on what type of special need car restraint he/she prescribed. After reaching a decision, the parent or guardian needs to either:
   a) have a health professional fill in and sign Part A of the Order and Prescription Form OR
   b) obtain a medical certificate from a G.P. or a medical specialist specifying the conditions and that the user needs one or more of the special needs car restraints. (Make a copy of this form for future use).
3. Parent or guardian is required to fill in and sign the declaration on the Part B of the Order and Prescription Form.
4. Funding body should forward their purchase order with of the following documents to FAS:
   (a) signed Order and Prescription Form,
   (b) copy of medical certificate.
5. Once a purchase order and the above documents have been received, your order will be processed.

FAS Therapeutic Equipment Pty Ltd
P.O. Box 840, 6 Bate Drive
Braeside Vic 3195 Australia
Tel 03-95876766 or 1300 303536
Fax 03-95876899 Email: sales@fasequipment.com

Wonderland Rehab & Child Care Products
P.O. Box 215, Unit 35, No 2 Railway Pde
Lidcombe NSW 2141 Australia
Tel 02-96494044 or 1300 303536
Fax 02-96494055 Email: jckh@fasequipment.com

www.fasequipment.com

Order and Prescription Form

Part A. Medical Certificate / Prescription Form & Declaration

*This part is completed by a Health Professional (O.T., G.P., or Physio etc).

I _____, working as a _____ for _____
request FAS Therapeutic Equipment P/L to supply:

_____ (Qty) of _____(car restraint) Value: $_____

for the SOLE USE by:_____(Name of User)

Deliver to: _____Suburb_____Postcode_____

The User is at risk of bodily injury while travelling in motor vehicles and a special need car restraint is prescribed because:

(Please tick All relevant boxes)

- ☐ The User has a behavioral disorder which causes the user to not remain restrainted by, or releases themselves from, the car safety restraint system, which may cause harm to himself, distract the driver or cause accident.
- ☐ The User has a physical disorder that requires a special need car restraint to enable safe and supportive seating while travelling in vehicle.
- ☐ The User has a medical condition that requires a special need car restraint to enable safe and supportive seating while travelling in vehicle.
- ☐ Other reason: _____

Prescriber's Declaration:

1. I have read the information for prescribing special need car restraints, and familiar with the relevant standards.
2. I have discussed with the parent/guardian of various option to transport the user safely and comfortably.
3. I will provide advice for the correct use of the prescribed car restraint to the carer who carry out transport duty so that they can follow the relevant protocols and regulations regarding restraint under the Relevant act for their service, e.g.- "Disability ACT 2006".
4. A review procedure is/are in place to review and monitor the suitability of the prescribed car restraint being used with the user.

Signed: _____ Date: _____ Phone No: _____ Fax No.:_____

Part B. Parent / Guardian Declaration

**This part is completed by the Parent/Guardian of the user.

I _____, Parent / Guardian of _____ (user), declare that:

1. I have discussed with _____, the above prescriber of various options to allow the user to be transported in vehicle safely and comfortably. I have read the information for special need car restraints.
2. I agree to source this prescribed special needs car restraint - _____(Product Name) from FAS therapeutic Equipment.
3. I give my approval to use this prescribed special need car restraint with the user, to other carer(s), centre staff, taxi driver(s), etc, to carry out the transport duty.
4. I have either had Part A completed by a health professional or obtained a Medical Certificate (copy enclosed with this form), for the use of the prescribed special needs car restraint with the user. I will be responsible to obtain an up-to-date medical certificate for review in conjunction with the prescriber from time to time.
5. I understand that a copy of all relevant documents pertaining to the use of the restraint should be kept in the vehicle(s) which the user travels in.

Parent/Guardian signed: _____ Contact Phone No: _____

Name: _____ Date: _____

Please send all documents to:

P.O. Box 840 Braeside Vic 3195,
or fax to 03-95876766, or 02-96494055, or email: sales@fasequipment.com