Equipment Program

Government of South Australia
Department of Human Services

Wig Request Form

Client Details	**(Internal Use only) ESIS ID:**
Phone	Date of Birth
Last name	First Name
Preferred Name	Gender M F Non-binary
Email	
Usual Address	Suburb Postcode
Interpreter required N Y - Primary Language:	
Alternate Contact (if applicable) Guardian Other Preferred contact Y N	
Name Relationship	Phone
Medical Practitioner Details	
Name	Provider Number
Clinic Name	
Email	Phone

Complete the following

Client has a permanent loss of hair as a result of a major illness or treatment of a major illness.

Diagnois relevant to hair loss: _____ (if alopecia please specify type)

How long has the client had this diagnosis: _____

Percentage of permanent scalp hair loss: _____

How long has the client experienced the above degree of scalp hair loss: _____

It is at least 12 months since the issue of a wig from an acute care service provider (eg hospital).

Not applicable

No alternate funding sources are available.

Medical Practioner Signature Date

Request Details

Type of wig requested Acrylic wig (must be at least 12-month since last provision of wig through EP)
Human hair wig (must be at least 5 years since last provision of wig through EP)

I have conducted my own research in chosing the above type of wig and understand my responsibility for maintaining the chosen wig if it is supplied under the Equipment Program (EP)

I have a preferred wig supplier (provide name and number)

I do not have a preferred supplier (Equipment Program will contact you to discuss supplier options)

Client / Guardian Signature Date

Submit to

Email request form to DHSEquipmentProgram@sa.gov.au **or fax to 1300 295 839**
You will be contacted with the outcome of this request. If approved you will be asked to get a quote.

Internal Use Only

Wig/s previously supplied by Equipment Program (List date of most recent wig provided) Not applicable
Date: Acrylic wig Human hair wig
Authorised by: Name **Signed** **Date**

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