Queensland Government

Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS 21
Artificial Larynx Application Form

This form is an appendix to the *MASS 21 Communication Aids Application Form* and must accompany all artificial larynx applications

(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

PART B – Clinical Assessment

Is urgent consideration requested for this application? ☐ Yes ☐ No

If yes, please provide justification:

1 **Applicant's permanent stabilised disability that necessitates the requested aid:**

Provide details about the type of surgery, presence of a tracheo-oesophageal puncture (TEP)/voice prosthesis, and any other relevant treatment e.g. radiation/chemoradiation:

Any other relevant medical history:

Comment on the applicant's abilities in the following areas:

Physical skills e.g. manual dexterity

Sensory skills e.g. hearing, vision

Cognitive skills:

Speech and language skills e.g. language impairment, dysarthria

Comment on relevant social and emotional factors:

2 **Does the applicant currently have use of a communication aid?** ☐ Yes ☐ No

If yes, supply brand/model:

Is this a MASS funded aid? ☐ Yes ☐ No If yes, supply plaque number (if applicable):

3 **If the applicant already has use of an artificial larynx, why does this need replacing?**

☐ Hired/borrowed ☐ Beyond repair (enclose statement from repairer)

☐ Lost or stolen ☐ Other (describe):

☐ Deterioration of device e.g. poor sound quality (as assessed by repairer)

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PART C – Clinical Justification and Trial of Artificial Larynx

4 Functional outcome expected from use of aid

Please tick the following and provide comments if necessary.

☐ Applicant will use the artificial larynx as his/her primary means of communication.

Comments:

☐ Applicant will use the artificial larynx as a secondary means to other methods of communication.

Comments:

NB: If applicant is using an artificial larynx as a secondary means of communication they must be educated to maintain it regularly so it is functional for emergency situations e.g. regular charging schedule.

5 Trial of artificial larynx

Brand/model of artificial larynx trialled:

Operational skills achieved when using the device: (rate accuracy (%) e.g. 75-100%, 50-75%, <50% accuracy)

Placement: A. Neck/cheek/intra-oral:

B. Accuracy of placement:

On/off timing of voice:

Articulatory precision:

Phasing/rate:

Intelligibility at phrase level: and connected speech:

Functional use of the device – comment on the following.

Independence in use of device:

Situations device used in e.g. familiar, unfamiliar, phone:

Frequency of use:

Were communication needs/goals met or can be met?

Applicant/family satisfaction:

Define outcomes that have determined success with the device:

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PART D – Artificial Larynx Requested

Brand	Model	Trial supplier (if applicable)

Note:
- Specific brand and model must be specified.
- If a similar aid is held within MASS stock, the stock aid may be issued in lieu.
- Artificial larynges will be delivered to the prescriber for programming.

PART E – Accessories Requested

List all accessories the applicant requires on the requested aid together with clinical justification to support MASS subsidy funding.

Modification / accessory	Clinical justification to support MASS subsidy funding

Does the applicant/carer understand the maintenance and use of this device in accordance with MASS and supplier procedures? ☐ Yes ☐ No

Is a safety switch installed in the applicant's home for items connected to mains power for charging/operation? ☐ Yes ☐ No

PART F – Prescriber Details To be completed in full for all applications

Prescriber Details (required for return correspondence and queries)

6 Name

Title	Family name
Given name(s)	

7 Profession

8 Eligible for practicing membership of Speech Pathology Australia? ☐ Yes ☐ No

9 Organisation name

10 Organisation address

Suburb / town	Postcode

11 Contact details

Telephone	Fax
Mobile	
Email	
Contact hours	

12 Signature

I certify that the information contained in this application is in accordance with the *MASS Statewide Prescriber Procedures Manual*.

✍ Date