# Consumables order variation

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| Health professionals complete this form with the *F004A Consumables prescription variation* form when requesting healthcare consumables for a participant or worker when there are only minor variations to a prescription before the next review. For additional information on how to complete this form, view *SP24 Completing consumables forms*.  |

## 1. Person’s details

|  |  |
| --- | --- |
| Name | Select scheme or program |
|   | [ ]  Lifetime Care [ ]  Workers Care |
| Participant number or claim number  |
|   |
| Address line 1 (street address, P.O Box, company, c/o) |
|   |
| Address line 2 (apartment, suite, unit, building, floor, etc.) |
|   |
| City | State/Territory | Postal code |
|   |   |   |
| Contact name (for deliveries) | Contact phone (mobile preferred) |
|   |   |
| Email address | Authority to leave delivery at front door |
|   | [ ]  Yes [ ]  No |

## 2. Order and review dates

Please provide full date if known, or estimated date if not confirmed:

|  |  |
| --- | --- |
| Order variation start date | Urgent  |
|   | [ ]  Yes [ ]  No |
| Is the variation to continue to next scheduled Consumable Prescription review? |
| [ ]  Yes[ ]  No – If no, please select variation end date  |
| Provider |
| [ ]  Brightsky Australia[ ]  Independence Australia |

## 3. Order

Refer to panel provider’s webstores to identify product codes and unit details:

* **Brightsky Australia**: brightsky.com.au/shop
* **Independence Australia**: store.independenceaustralia.com

Add more rows as required.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Product code** | **Description** | **Quantity** | **Unit type** | **Frequency**E.g. one off supply, monthly, 3 monthly, 6 monthly etc(“as required” is not acceptable) | **What is to be amended or removed?** |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |  |

## 4. Prescriber declaration

I declare that the participant or worker named above, requires the requested consumable products, to manage their injury-related continence, respiratory, nutritional and skin integrity needs.

This prescription has been developed in consultation with participant or worker named above in collaboration with their family member or nominated person if necessary. All people involved in conversations with this prescription agree with it.

### Prescriber details

|  |  |
| --- | --- |
| Name | Qualification |
|   |   |
| Phone | Days/hours available |
|   |   |
| Email |
|   |
| Address line 1 (street address, P.O Box, company, c/o) |
|   |
| Address line 2 (apartment, suite, unit, building, floor, etc) |
|   |
| City | State/Territory | Postal code |
|   |   |   |
| Signature | Date |
|  | Click or tap to enter a date. |

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| Please email completed form and F003A Consumables Order to icare: care-requests@icare.nsw.gov.au and include the following in the subject header: Consumables Request [Participant/Worker name] [Participant/Worker reference number]Please email this form only to the selected panel provider:* Brightsky Australia: icarecc@brightsky.com.au OR
* Independence Australia: icare@iagroup.org.au
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| **For queries relating to orders or products please contact the provider directly:**Brightsky Australia: phone **1300 88 66 01** or email: icarecc@brightsky.com.au Independence Australia: phone **1300 793 133** or email: icare@iagroup.org.au  |

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|  | **icare**GPO Box 4052, Sydney NSW 2001**General Phone Enquiries: 1300 738 586**Email: care-requests@icare.nsw.gov.auwww.icare.nsw.gov.au |