# Consumables prescription

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| Health professionals complete this form with the *F003B Consumables order* form when requesting healthcare consumables for a participant or worker following a comprehensive assessment of their injury related needs. For additional information on how to complete this form, view *SP24 Completing consumables forms.*  |

## 1. Person’s details

|  |  |
| --- | --- |
| Name | Scheme or program |
|   | [ ]  Lifetime Care [ ]  Workers Care |
| Participant number or claim number | Date of injury | Age |
|   | Click or tap to enter a date. |   |
| Injury |
| [ ]  TBI [ ]  SCI – Level: ASIA Score: [ ]  Other:  |

## 2. Identification of need

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| --- |
| Injury related condition requiring consumable products (e.g. neurogenic bladder, renal calculi, stoma sites, pressure areas, pre-existing stress or urge incontinence, functional incontinence, dysphagia) |
|   |

## 3. Continence

|  |
| --- |
| 3.1 Current bowel management *(frequency, assistance required, equipment and medications currently used)* |
|   |
| 3.2 Recommended bowel management *(frequency, assistance required, additional equipment needed, changes in medications)* |
|   |
| 3.3 Current bladder management *(frequency, assistance required, equipment and medications currently used)* |
|   |
| 3.4 Recommended bladder management *(frequency, assistance required, additional equipment needed, changes in medications)* |
|   |

## 4. Skin integrity

|  |
| --- |
| 4.1 Current management of skin integrity including any current wounds *(frequency, assistance required, products currently used)* |
|   |
| 4.2 Recommended management of skin integrity *(frequency, assistance required, products needed)* |
|   |

## 5. Respiratory

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| --- |
| 5.1 Current respiratory consumable management *(what consumables are used e.g. nebuliser)* |
|   |
| 5.2 Recommended respiratory consumable management *(what consumables are needed)* |
|   |

## 6. Nutrition

|  |  |
| --- | --- |
| 6.1 Does the person require nutritional supplements? | 6.2 Does the person require a dietitian review? |
| [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| 6.3 Current nutritional consumables required |
|   |
| 6.4 Recommended nutritional consumables |
|   |

## 7. Other consumable products

Only complete this section if the person requires other consumable products not covered by 3 to 6, e.g. management of autonomic dysreflexia.

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| --- |
| 7.1 Current management |
|   |
| 7.2 Recommended management |
|   |

## 8. Additional Information

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| If you are recommending products that are not included in the Consumable Panel provider’s product list, or the quantity is above what is recommended, please provide justification below |
|   |

## 9. Provider details

|  |
| --- |
| Please advise the panel provider the participant or worker has chosen to receive products from |
| [ ]  Brightsky Australia[ ]  Independence Australia |
| Please outline reason for choosing the above provider |
|   |

## 10. Attachments

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| --- |
| Reports, documents or quotes attached *(please list all attachments included with this request)* |
| [ ]  Yes - [ ]  No |

## 11. 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. |

|  |
| --- |
| Please email completed form and *F003B Consumables Order* form 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]Do NOT send this form to the chosen provider. |

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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 |