# Prosthetic request form

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| Once completed please email this form to: care-requests@icare.nsw.gov.au and include the following in the subject header: Prosthetic request [person’s name and number] [icare contact name] |

## ****1. Person’s details****

|  |  |
| --- | --- |
| **Name** | **Participant number or claim number** |
|   |   |
| **Street address** |
|   |
| **Suburb** | **State** | **Postcode** |
|   |   |   |
| **Contact name** | **Contact phone** |
|   |   |
| **Date of injury** | **Age** |
| Click or tap to enter a date. |   |
| **Other injuries which may impact on use of prosthesis *(e.g. TBI)*** |
|   |

**2. Amputation details**

|  |
| --- |
| Level of amputation |
|   | [ ]  Left [ ]  Right [ ]  Bilateral  |
| Date of amputation | Current weight (kg) |
| Click or tap to enter a date. |  |
| Lower limb K classification |
| [ ]  K0 [ ]  K1 [ ]  K2 [ ]  K3 [ ]  K4 |
| Upper limb potential prosthetic function |
|   |

**3. Proposed prescription**

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| --- |
| Prescription type |
| [ ]  New prosthesis [ ]  Change of prescription of existing prosthesis [ ]  Direct replacement of a previous prosthesis |
| Prosthetic request |
| [ ]  Interim [ ]  Definitive [ ]  Recreational  |

|  |  |  |  |
| --- | --- | --- | --- |
| a) Components | Description | Code\* | Cost |
| **Socket** |   |   |   |
| **Suspension** |   |   |   |
| **Foot / terminal device** |   |   |   |
| **Ankle / wrist** |   |   |   |
| **Knee / elbow** |   |   |   |
| **Hip / shoulder** |   |   |   |
| **Consumables \*\*** |   |   |   |
| **Cosmesis** |   |   |   |
| **Other** |   |   |   |
| *\* Code for Lifetime Care is LTCS704. Code for Workers Care is MOB001.**\*\* Please detail socks / liner / sleeves needed for the subsequent 12 months.* |
| b) Clinical services |
| Clinical assessment including goal setting |  hrs @ per hour |   |
| Liaise with other health professionals |  hrs @ per hour |   |
| Device specification / measurement e.g. casting, measuring |  hrs @ per hour |   |
| Fabrication / modification |  hrs @ per hour |   |
| Fitting and adjustment |  hrs @ per hour |   |
| User education / training e.g. general maintenance, gait retraining |  hrs @ per hour |   |
| Ongoing review(s) (over the next 12 months) |  hrs @ per hour |   |
| Administration  |  hrs @ per hour |   |
| **Total** |   |

**4. Prosthetic justification**

a) Goal setting

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| Goal in person’s words |
|   |
| S.M.A.R.T goal |
|   |
| Step description (how will we get there?) |
|   |
| b) Describe why the person needs this prosthesis. How often is this prosthesis likely to be used? |
|   |
| c) Provide justification for the features/specifications of the proposed prosthesis. Summarise assessment findings relevant to the prescription. e.g. range of motion, strength, interpretation of valid and reliable outcome measures as appropriate (e.g. AMPPRO, DASH, TUG) |
|   |
| d) Can the worker don and doff the prosthesis independently? If not, what assistance is required? |
|   |
| e) Does the person require any training to use the proposed prosthesis? Please detail type of training, duration, who is responsible for providing training and any additional costs associated with training. |
|   |
| f) Are other assistive devices used in conjunction with the prosthesis? |
|   |
| g) Other information relevant to the prescription. |
|   |

**5. Warranty details**

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| a) Please detail warranty associated with all major components (e.g. joints, feet, terminal devices) including duration and cost. Please attach copy of warranty documents. |
|   |
| b) Detail of servicing schedule and how it will be implemented (who is responsible for coordinating?) |
|   |

**6. Alternate prosthetic considerations**

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| What other prosthetic options / components were considered or trialed? Why are they not appropriate? |
|   |

**7. Other prosthesis**

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| Does the person have other prostheses? |
| [ ]  No (go to section 8) [ ]  Yes, please give details |

|  |  |  |
| --- | --- | --- |
| Date fitted | Details (components used etc.) | Type (e.g. recreational) |
| Click or tap to enter a date. |  |  |
| Click or tap to enter a date. |  |  |
| Click or tap to enter a date. |  |  |
| Click or tap to enter a date. |  |  |

**8. Prosthetist’s authorisation and declaration**

I have discussed the information provided in this request with the worker and treating team, including the prosthetic components requested and the aims / predicted outcomes / maintenance and training requirements.

|  |  |  |
| --- | --- | --- |
| **All recommendations have been agreed to by** | Prescribing rehabilitation specialist (name) |   |
| Treating team (clinicians name/s) |   |
| Location (e.g. hospital) |   |
| Date | Click or tap to enter a date. |

|  |  |
| --- | --- |
| Prescribing prosthetist’s name | Days / hours available |
|   |  |
| Prescribing prosthetist’s qualifications | Date |
|   | Click or tap to enter a date. |
| Provider name, address, phone number | Signature |
|   |  |

Please email completed form to:

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