# Prosthetic request form

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| Once completed please email this form to: [care-requests@icare.nsw.gov.au](mailto: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)*** | | | |
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**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 | |
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**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 |

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| --- | --- | --- | --- | --- |
| 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 |
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| S.M.A.R.T goal |
|  |
| Step description (how will we get there?) |
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| 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. |
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| f) Are other assistive devices used in conjunction with the prosthesis? |
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| g) Other information relevant to the prescription. |
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**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. |
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| b) Detail of servicing schedule and how it will be implemented (who is responsible for coordinating?) |
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**6. Alternate prosthetic considerations**

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

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| **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:

|  |  |
| --- | --- |
|  | icare GPO Box 4052, Sydney, NSW 2001 **General Phone Enquiries: 1300 738 586** Email: [care-requests@icare.nsw.gov.au](mailto:care-requests@icare.nsw.gov.au) www.icare.nsw.gov.au |