# Prosthetic Repair / Replacement Request Form

Once completed please e-mail 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 Repair / Replacement Request [Person’s name] [Person’s participant number or claim number]

### Person’s Details

|  |  |
| --- | --- |
| Name | Participant number or Claim number |
|  |  |
| Address | |
|  | |
| Contact name | Contact phone |
|  |  |
| Date of injury | Age |
|  |  |
| Other injuries which may impact on use of prosthesis (e.g. TBI) | |
|  | |

### Amputation Details

|  |  |  |
| --- | --- | --- |
| Level of amputation |  | |
|  | Left  Right  Bilateral | |
| Date of amputation | | Current weight (kgs) |
|  | |  |
| Prosthetic Function Status / K Classification (Note: not required for upper limb) | | |
| K0  K1  K2  K3  K4 | | |
| Upper limb potential function | | |
|  | | |

### Current Prosthesis

|  |  |
| --- | --- |
| Date fitted | Type (e.g. recreational) |
|  |  |
| Detail current prosthesis requiring repair and replacement or consumables | |
|  | |

### Type of Request

|  |
| --- |
| Repair  Replacement  Consumables |
| Is the need of repair, replacement or consumables due to incorrect use, damage or loss? |
| No  Yes, please provide details: |
| Warranty |
| No  Yes (*If these components or consumables are covered under warranty, please provide details of why it is not being repaired or replaced under warranty):* |

### Prescription

|  |
| --- |
| Prescription request |
| Consumables  Change of prescription of existing prosthesis  Direct replacement of a previous prosthesis |
| Type of prosthesis |
| Interim  Definitive  Recreational |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Components | Description | Warranty | 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 | | | | |
| Clinical services | | | | |
| Prolonged consultation | hrs @       per hour | | |  |
| Labour | hrs @       per hour | | |  |
| TOTAL | | | |  |

### Prosthetic Justification

|  |
| --- |
| Detail what is being requested |
|  |
| Provide justification as to why it is being requested |
|  |
| Detail what alternatives have been considered and discounted |
|  |

### Warranty details

|  |
| --- |
| 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?) |
|  |

### Prosthetist’s Authorisation and Declaration

### I have discussed the information provided in this request with the participant/worker

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | | Phone number | | |
|  | |  | | |
| Address | | | | |
|  | | | | |
| Days / hours available | | | Qualifications | |
|  | | |  | |
| Signature | | | Date | |
| Signature | | | Click or tap to enter a date. | |
|  | | | | |
|  | **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 | | |