# Prosthetic Repair / Replacement Request Form

Once completed please e-mail this form to: 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.auwww.icare.nsw.gov.au |