# Prosthetic request form

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| Once completed please email this form to: ctpcare@icare.nsw.gov.au and include the following in the subject header: Prosthetic request [client’s name and claim number] [CTP Care contact name] |

## ****1. Client’s details****

|  |  |
| --- | --- |
| **Name** | **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

|  |
| --- |
| **Prescription type** |
| [ ]  **New prosthesis** [ ]  **Change of prescription of existing prosthesis**[ ]  **Direct replacement of 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** |   |   |   |
| *\* Please provide details for socks / liners / 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 client’s words** |
|   |
| **S.M.A.R.T goal** |
|   |
| **Step description (how will we get there?)** |
|   |
| **b) Describe why the client 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 person don and doff the prosthesis independently? If not, what assistance is required?** |
|   |
| **e) Does the client 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 client 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 client 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:

|  |  |
| --- | --- |
|  | CTP CareEmail: ctpcare@icare.nsw.gov.au**General Phone Enquiries: 1300 738 586** |