# Prosthetic request form

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| Once completed please email this form to: [ctpcare@icare.nsw.gov.au](mailto: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

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| **Prescription type** |
| **New prosthesis  Change of prescription of existing prosthesis**  **Direct replacement of 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** |  | |  |  |
| *\* 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** |
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| **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.** |
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| **f) Are other assistive devices used in conjunction with the prosthesis?** |
|  |
| **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 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.

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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:

|  |  |
| --- | --- |
|  | CTP Care  Email: ctp[care@icare.nsw.gov.au](mailto:care@icare.nsw.gov.au)  **General Phone Enquiries: 1300 738 586** |