# Consumables prescription

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| Health professionals complete this form with the *FCTPSP06b Consumables order* form when requesting healthcare consumables for a client following a comprehensive assessment of their injury related needs. |

## Person’s details

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | | | | |
|  | | | | |
| Claim number | | Date of injury | | Age |
|  | Click or tap to enter a date. | |  | |
| Injury | | | | |
|  | | | | |

## Identification of need

|  |
| --- |
| Injury related condition requiring consumable products (*e.g. pressure care, personal care, incontinence, nutritional supplements*) |
|  |

## Continence

For questions 3 – 6 only complete sections relevant to the person’s injury related need

|  |
| --- |
| * 1. Current bowel management *(frequency, assistance required, equipment and medications currently used)* |
|  |
| * 1. Recommended bowel management *(frequency, assistance required, additional equipment needed, changes in medications)* |
|  |
| * 1. Current bladder management *(frequency, assistance required, equipment and medications currently used)* |
|  |
| * 1. Recommended bladder management *(frequency, assistance required, additional equipment needed, changes in medications)* |
|  |

## Skin integrity

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| --- |
| * 1. Current management of skin integrity including any current wounds *(frequency, assistance required, products currently used)* |
|  |
| * 1. Recommended management of skin integrity *(frequency, assistance required, products needed)* |
|  |

## Respiratory

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| --- |
| * 1. Current respiratory consumable management *(what consumables are used e.g. nebuliser)* |
|  |
| * 1. Recommended respiratory consumable management *(what consumables are needed)* |
|  |

## Nutrition

|  |  |
| --- | --- |
| * 1. Does the person require nutritional supplements? | * 1. Does the person require a dietitian review? |
| Yes  No | Yes  No |
| * 1. Current nutritional consumables required | |
|  | |
| * 1. Recommended nutritional consumables | |
|  | |

## Other consumable products

Only complete this section if the person requires other consumable products not covered by 3 to 6

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| --- |
| * 1. Current management |
|  |
| * 1. Recommended management |
|  |

1. **Additional Information**

|  |
| --- |
| If you are prescribing a quantity above what is recommended, please provide justification below |
|  |

1. **Provider details**

|  |
| --- |
| Please advise the provider the client has chosen to receive products from |
| Brightsky Australia  Independence Australia  Other |

1. **Additional Information**

|  |
| --- |
| Reports, documents or quotes attached *(please list all attachments included with this request)* |
| Yes -   No |

## Prescriber details

|  |  |  |  |
| --- | --- | --- | --- |
| Name | | Qualification | |
|  | |  | |
| Phone | | Days/hours available | |
|  | |  | |
| Email | | | |
|  | | | |
| Address line 1 (street address, P.O Box, company, c/o) | | | |
|  | | | |
| Address line 2 (apartment, suite, unit, building, floor, etc) | | | |
|  | | | |
| City | State/Territory | | Postal code |
|  |  | |  |
| Signature | | Date | |
|  | | Click or tap to enter a date. | |

|  |
| --- |
| **Please email completed form and *FCTPSP06b Consumables Order* form to icare:**  [**ctpcare@icare.nsw.gov.au**](mailto:ctpcare@icare.nsw.gov.au)  and include the following in the subject header: Consumables Request [Client’s name and claim number] [CTP Care contact name] |

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