# 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

|  |
| --- |
| * 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

|  |
| --- |
| * 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**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.auwww.icare.nsw.gov.au |