# Consumables prescription

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| Health professionals complete this form with the *F003B Consumables order* form when requesting healthcare consumables for a participant or worker following a comprehensive assessment of their injury related needs.  For additional information on how to complete this form, view *SP24 Completing consumables forms.* |

## 1. Person’s details

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | | Scheme or program | | |
|  | | Lifetime Care  Workers Care | | |
| Participant number or claim number | Date of injury | | | Age |
|  | Click or tap to enter a date. | |  | |
| Injury | | | | |
| TBI  SCI – Level: ASIA Score:  Other: | | | | |

## 2. Identification of need

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| Injury related condition requiring consumable products (e.g. neurogenic bladder, renal calculi, stoma sites, pressure areas, pre-existing stress or urge incontinence, functional incontinence, dysphagia) |
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## 3. Continence

|  |
| --- |
| 3.1 Current bowel management *(frequency, assistance required, equipment and medications currently used)* |
|  |
| 3.2 Recommended bowel management *(frequency, assistance required, additional equipment needed, changes in medications)* |
|  |
| 3.3 Current bladder management *(frequency, assistance required, equipment and medications currently used)* |
|  |
| 3.4 Recommended bladder management *(frequency, assistance required, additional equipment needed, changes in medications)* |
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## 4. Skin integrity

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| --- |
| 4.1 Current management of skin integrity including any current wounds *(frequency, assistance required, products currently used)* |
|  |
| 4.2 Recommended management of skin integrity *(frequency, assistance required, products needed)* |
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## 5. Respiratory

|  |
| --- |
| 5.1 Current respiratory consumable management *(what consumables are used e.g. nebuliser)* |
|  |
| 5.2 Recommended respiratory consumable management *(what consumables are needed)* |
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## 6. Nutrition

|  |  |
| --- | --- |
| 6.1 Does the person require nutritional supplements? | 6.2 Does the person require a dietitian review? |
| Yes  No | Yes  No |
| 6.3 Current nutritional consumables required | |
|  | |
| 6.4 Recommended nutritional consumables | |
|  | |

## 7. Other consumable products

Only complete this section if the person requires other consumable products not covered by 3 to 6, e.g. management of autonomic dysreflexia.

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| --- |
| 7.1 Current management |
|  |
| 7.2 Recommended management |
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## 8. Additional Information

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| If you are recommending products that are not included in the Consumable Panel provider’s product list, or the quantity is above what is recommended, please provide justification below |
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## 9. Provider details

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| Please advise the panel provider the participant or worker has chosen to receive products from |
| Brightsky Australia  Independence Australia |
| Please outline reason for choosing the above provider |
|  |

## 10. Attachments

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

## 11. 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. | |

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| Please email completed form and *F003B Consumables Order* form to icare:  [care-requests@icare.nsw.gov.au](mailto:care-requests@icare.nsw.gov.au)  and include the following in the subject header: Consumables Request [Participant/Worker name] [Participant/Worker reference number]  Do NOT send this form to the chosen provider. |

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