# Consumables order

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| Health professionals complete this form with the *F003A Consumables prescription* 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 | Participant number or claim number |
|   |   |
| Select scheme or program |
| [ ]  Lifetime Care [ ]  Workers Care |
| 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 |
|   |   |   |
| Contact name (for deliveries) | Contact phone (mobile preferred) |
|   |   |
| Email address | Authority to leave delivery at front door |
|   | [ ]  Yes [ ]  No |

## 2. Order information

This prescription is a:

|  |  |  |
| --- | --- | --- |
| [ ]  Discharge prescription | [ ]  New/revised prescription | [ ]  Amendment to an existing order |
| Urgent | Panel provider |
| [ ]  Yes[ ]  No | [ ]  Brightsky Australia[ ]  Independence Australia |

## 3. Order and review dates

Please provide full date if known, or estimated date if not confirmed

|  |  |
| --- | --- |
| Order start date | Order end date |
| Click or tap to enter a date. | Click or tap to enter a date. |
| Next review date |
| Click or tap to enter a date. |

## 4. Order

Refer to panel provider’s webstores to identify product codes and unit details:

* **Brightsky Australia**: brightsky.com.au/shop
* **Independence Australia**: store.independenceaustralia.com

Add more rows as required.

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| **Continence products** |
| **Product code** | **Description** | **Quantity** | **Unit type**e.g. box, carton, packet, single unit | **Frequency**E.g. one off supply, monthly, 3 monthly, 6 monthly etc(“as required” is not accepted) |
| *e.g. X1234* | *Catheter ABC* | *3* | *boxes* | *monthly* |
|   |   |   |   |   |
|   |   |   |   |  |

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| **Skin integrity products** |
| **Product code** | **Description** | **Quantity** | **Unit type**e.g. box, carton, packet, single unit | **Frequency**E.g. one off supply, monthly, 3 monthly, 6 monthly etc(“as required” is not acceptable) |
|   |   |   |   |   |
|   |   |   |   |  |

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| **Respiratory products** |
| **Product code** | **Description** | **Quantity** | **Unit type**e.g. box, carton, packet, single unit | **Frequency**E.g. one off supply, monthly, 3 monthly, 6 monthly etc(“as required” is not acceptable) |
|   |   |   |   |   |
|   |   |   |   |  |

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| **Nutritional products** |
| **Product code** | **Description** | **Quantity** | **Unit type**e.g. box, carton, packet, single unit | **Frequency**E.g. one off supply, monthly (“as required” is not acceptable) |
|   |   |   |   |   |
|   |   |   |   |  |

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| **Other products** |
| **Product code** | **Description** | **Quantity** | **Unit type**e.g. box, carton, packet, single unit | **Frequency**E.g. one off supply, monthly, 3 monthly, 6 monthly etc(“as required” is not acceptable) |
|   |   |   |   |   |
|   |   |   |   |  |

## 5. Required delivery cycle

|  |  |  |
| --- | --- | --- |
| [ ]  Monthly | [ ]  3-monthly |  |
| Other (specify) |
| [ ]  Standing order | [ ]  Provider to make contact | [ ]  Person/Prescriber to make contact |

* *Please note that a delivery cycle of less than one month can only be requested if storage problems exist*
* *Please note that the supplier will make forward ordering arrangements according to the selected delivery cycle*

## 6. Prescriber declaration

I declare that the participant or worker named above, requires the requested consumable products, to manage their injury-related continence, respiratory, nutritional and skin integrity needs.

This prescription has been developed in consultation with the participant or worker named above in collaboration with their family member or nominated person if necessary. All people involved in conversations with this prescription agree with it.

### 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 *F003A Consumables Order* to icare: care-requests@icare.nsw.gov.au and include the following in the subject header: Consumables Request [Participant/Worker name] [Participant/Worker reference number]Please email this form only to the selected panel provider:* Brightsky Australia: icarecc@brightsky.com.au OR
* Independence Australia: icare@iagroup.org.au
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| **For queries relating to orders or products please contact the provider directly:**Brightsky Australia: phone **1300 88 66 01** or email: icarecc@brightsky.com.au Independence Australia: phone **1300 793 133** or email: icare@iagroup.org.au  |

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|  | **icare**GPO Box 4052, Sydney NSW 2001**General Phone Enquiries: 1300 738 586**Email: care-requests@icare.nsw.gov.auwww.icare.nsw.gov.au |