**Logo

Description automatically generated**

**Continence and consumables request form**

|  |
| --- |
| **Completing the continence and consumables request form**  This prescription should include:   * Current management protocol of the continence, respiratory, skin integrity and/or nutritional needs and proposed management of those needs. * The quantity and frequency of provision (as per best practice, manufacturer guidelines, and clinical assessment).   Please email this form directly to the participant’s nominated support planner. If details are unknown, please call 1300 607 566 or email [enquiries@niis.qld.gov.au](mailto:enquiries@niis.qld.gov.au). |

**Participant information**

|  |  |  |  |
| --- | --- | --- | --- |
| Date |  | Participant case number |  |
| Participant name |  |  |  |
| Date of accident |  | Age |  |
| Contact name  (***for deliveries)*** |  | Contact phone  (***for deliveries***) |  |
| Delivery address |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Accident-related injuries (NIISQ eligible injury) *please select* | | | Other (specify) |
| Traumatic brain injury |  |  |  |
|  |  |  |
| Spinal cord injury |  |  |
|  |  |  |
| Level |  | |
|  |  |  |
| ASIA score |  | |

**Prescription completed by**

|  |  |  |  |
| --- | --- | --- | --- |
| Full name |  | | |
| Qualification and position held |  | | |
| Organisation |  | | |
| Phone |  | Email |  |

**Attachments**

|  |  |  |
| --- | --- | --- |
| Reports/documents attached: *(please list any reports or documents (such as quotes) included with this request)* | | |
| Reports / documents attached | Yes | No |
| List of reports / documents |  | |

**Order information**

|  |  |  |
| --- | --- | --- |
| This prescription is a: | | |
| Discharge prescription | New / revised prescription | Amendment to an existing order |

**Order and review dates**

|  |  |  |  |
| --- | --- | --- | --- |
| *Please provide full date if known, or estimated date if not confirmed* | | | |
| Order start date |  | Order end date |  |
| Next review date | *If required* | | |

**Identification of need**

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

**Continence**

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

**Skin integrity (including wound management)**

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

**Respiratory (including ventilation needs)**

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

**Nutritional (\*only Dieticians or Speech Pathologists are able to prescribe)**

|  |  |  |
| --- | --- | --- |
| Does the participant require nutritional supplements? | Yes | No |
| Does the participant require a Dietician review? | Yes | No |
| Current nutritional consumables required | | |
|  | | |
| Recommended nutritional consumables required | | |
|  | | |

**Other consumable products**

|  |
| --- |
| *Only complete this section if the participant requires other consumables not covered by points 3 to 6.* |
| Current management |
|  |
| Recommended management |
|  |

**Additional information**

|  |
| --- |
| *Any additional relevant information* |
|  |

**Prescription** *(please add additional rows as required)*

|  |  |  |  |
| --- | --- | --- | --- |
| Supplier details (chosen by participant / family / guardian | |  | |
| Supplier code | Description | Quantity/Units | Frequency  *E.g. one-off supply, monthly,  3 monthly, 6 monthly etc* |
| **CONTINENCE PRODUCTS** | | | |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **SKIN INTEGRITY PRODUCTS** | | | |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **RESPIRATORY PRODUCTS** | | | |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **NUTRITIONAL PRODUCTS** | | | |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **OTHER PRODUCTS** | | | |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Service Provider declaration**

This prescription has been developed in consultation with the participant and in collaboration with their family member or nominated person (if necessary). The participant (and family member or nominated person) agrees with the prescription.

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Date |  |