National Injury Insurance Agency, Queensland

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](http://enquiries@niis.qld.gov.au/).

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| Participant’s details |
| Participant name |  | NIISQ case number |  |
| Delivery Address |  |
| City/suburb |  |
| State |  | Postcode |  |
| Date of accident |  | Age |  |
| Contact name*(for deliveries)* |  | Contact phone*(for deliveries)* |  |
| Delivery Address |  |
| City/suburb |  |
| State |  | Postcode |  |
| Injuries and other medical conditions |
| Serious personal injury[ ]  TBI [ ]  SCI | Level  | Other personal injuries (specify) |
| ASIA score  |
| Pre-existing injuries or medical conditions |  |
| Prescription completed by |
| Name |  |
| Qualification |  | Position |  |
| Organisation |  |
| Phone |  | Email |  |
| Attachments *Please list any reports or documents (such as quotes) included with this request* |
| Reports/documents are attached? | [ ]  Yes [ ]  No |
| List of reports/ documents |  |

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| 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 |
| Accepted 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)* |

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| 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 productsOnly complete this section if the participant requires other consumables not stated above. |
| Current management |
| Recommended management |
| Additional information |
| Detail any additional relevant information |

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| Prescription (please add additional pages as required) |
| Supplier details *(chosen by participant/family/guardian)* |
| Supplier code | Description | Quantity/units | Frequency |
| *e.g.* | *e.g.* | *e.g.* | *e.g. one-off supply, monthly, 3 monthly, 6 monthly, etc.* |
| Continence products |
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| Skin integrity products |
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| Respiratory products |
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| Nutritional products |
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| Other products |
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| Service provider declarationThis prescription has been developed in consultation with the participant and in collaboration with their family member or nominated guardian (if necessary). The participant agrees with the prescription. |
| Name |  | Date |  |

**Sensitive information:** This form collects sensitive information about you, such as your health details or ethnicity. By submitting this form, you consent to NIISQ collecting and handling this information.

NIISQExForm12v4

**Privacy statement:** We are collecting your personal information in order to perform our functions under the NIISQ Act. We collect, use, disclose and store your personal information in accordance with the *Information Privacy Act 2009 (Qld)*, the *National Injury Insurance Scheme (Queensland) Act 2016* (NIISQ Act) and the *National Injury Insurance Scheme (Queensland) Regulation 2016* (NIISQ Regulation). If we cannot collect this information, we may not be able to assist you. It is our usual practice to disclose your personal information to the Permitted Entities prescribed in s14 NIISQ Regulation and mandated by s19(3) of the NIISQ Act. Your personal information will not otherwise be released unless the disclosure is permitted or required

by law. Further information on how we handle your personal information can be found in our privacy policy including how to access or update your information. You can also contact our Privacy Officer on 1300 607 566 or privacy@niis.qld.gov.au



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