

National Injury Insurance Agency, Queensland  
**Contenance and consumables  
 request form**



**Completing the contenance and consumables request form**

This prescription should include:

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

## 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)*

## 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 stated above.

Current management

Recommended management

## Additional information

Detail any additional relevant information

**Prescription** (please add additional pages as required)**Supplier details** (chosen by participant/family/guardian)

Supplier code	Description	Quantity/units	Frequency
<i>e.g.</i>	<i>e.g.</i>	<i>e.g.</i>	<i>e.g. one-off supply, monthly, 3 monthly, 6 monthly, etc.</i>

**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 guardian (if necessary). The participant agrees with the prescription.

<b>Name</b>		<b>Date</b>	
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