Australian Government
Department of Health

Deodorant and Absorption Gelling Sachets Authorisation Form

Product information

Deodorant and absorption gelling sachets are thickening agents to manage high liquid output.

Restrictions on use

If the patient meets the criteria below, they must be assessed by an authorised health professional to rule out other underlying problems associated with deodorant and absorption gelling sachets.

An **authorised health professional** can be either: stomal therapy nurse, nurse practitioner, registered nurse, or a registered medical professional.

Criteria

- Patient must have high liquid output.

Privacy notice

Your personal information is protected by law including the Privacy Act 1988 and the Australian Privacy Principles and is being collected by your Stoma Association for the primary purpose of issuing deodorant and absorption gelling sachets as requested by the patient's health professional.

You can get more information about the way in which your stoma association will manage your personal information, including its privacy policy at **australianstoma.com.au/privacy-policy**

Patient Consent

I, the patient declare that:

- I consent to the collection of my personal information, including sensitive information, by my Stoma Association and the Australian Council of Stoma Associations Inc (ACSA) for the purposes indicated in this form.

Full name of patient

Signature of patient

✍

Date

/ /

Authorisation to order product

Authorised health professional

I authorise:

- the patient to order the deodorant and absorption gelling sachets from their Stoma Association.

I, the authorised health professional, declare that:

- the patient has received education from me and has agreed to return for a review within six months of initial consultation.

Full name of authorised health professional

Signature of authorised health professional

✍

Date

/ /

Note: The deodorant and absorption gelling sachets must be ordered within two months of this authorisation date

Stoma Association's details

To be completed and signed by patient's Stoma Association

Full name of patient

Patient Stoma Association membership number

Name of nominated Stoma Association

Signature of Stoma Association's authorised person

✍

Date

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