Thickening Agent Authorization Form

I,________________________ give ________________________ authority to use an
(STN/Health practitioner name) (Patient name)

R1 restricted gelling/thickening agent as listed on the Stoma Appliance Scheme schedule.

I have instructed the above mentioned patient in the correct use and maximum issue quantity of the restricted product.

STN/Health practitioner signature__________________________ Date___________

Patient signature____ Date___________

<u>Health practitioner information</u>

Family name____

First given name____

Professional title____

Referring practitioner number or AHPRA registration number____________________

Practice location____

____Postcode___________

<u>Patient information</u>

Family name____

First given name____

Stoma association membership number_____________________________________