Queensland Stoma Association

Unit 1, 10 Valente Close, Chermside 4032
Post Office Box 370, Chermside South 4032

Website: qldstoma.asn.au
Email: admin@qldstoma.asn.au
Telephone: (07) 3359 7570
Facsimile: (07) 3350 1882

ORDER FORM

ORDERS ARE PROCESSED WITHIN STOMA APPLIANCE SCHEME RULES

SURNAME: **GIVEN NAMES:**	**STOMA APPLIANCE ENTITLEMENT CARD NO** _____
POSTAL ADDRESS:	Office Use Only Received:
SUBURB: **POSTCODE:**	Goods Issued:
PLEASE INDICATE IF POSTAL ADDRESS HAS CHANGED SINCE LAST ORDER ☐	
TELEPHONE NO: - **EMAIL: -**	

DELIVERY OPTION – PLEASE TICK ONE

☐ **PICK UP** ☐ **POST – please ensure correct postage has been paid** ☐ **POST - DVA APPROVED**

FOR THE MONTH OF _____

MEDICARE CARD DETAILS (must be completed)

MEDICARE CARD NO ☐☐☐☐ ☐☐☐☐☐ ☐ INDIV REF ☐ EXPIRY ☐☐/☐☐☐☐

By submitting this order, I consent to QLD Stoma Association Ltd verifying my Medicare information with Services Australia. I also confirm that all products provided to me through the Stoma Appliance Scheme are for my own personal use.

Signed: _____

PRODUCT CODE*	BRAND	ITEM OR DESCRIPTION	QTY IN PACK	# PACKS ORDERED	OFFICE USE ONLY
NON-SAS ITEMS PURCHASED:					

Members must ensure that the product code quoted is correct as goods will be supplied in accordance with this code. QSA recommends that the advice of an STN or medical practitioner be sought before using products which have not previously been used. Information provided by QSA about the availability and/or features of any product is not intended to be an advice or recommendation as to the suitability of that product for use.

PAYMENT OPTIONS:

POSTAGE	$15 per parcel (Interstate parcels may incur a surcharge to cover additional freight cost).....	$_____
NON-SAS ITEMS	Refer QSA pharmaceuticals item list	$_____
SAS ACCESS FEE	$70 full/$60 Concession due 1 July each year)	$_____
DONATION	Donations of $2 and over are tax deductible	$_____
2% CARD FEE	For payments made by visacard or mastercard	$_____

PAYMENT METHOD (Do not send cash): **TOTAL** $_____

☐ Cheque/Money Order ☐ Prepaid balance

☐ Visa/Mastercard (+2% fee) Card No _ _ _ _ / _ _ _ _ / _ _ _ _ / _ _ _ _ Expiry: ____/____ CCV: _____

Card Name: _____ Signed: _____

ONCE AN ORDER FORM HAS BEEN SUBMITTED, WE MAY NOT BE ABLE TO MAKE ALTERATIONS