Australian Government
Department of Human Services

medicare

PBS

Stoma Appliance Scheme application

Purpose of this form

Complete Part 1 of this form to indicate your eligibility to receive products under the Stoma Appliance Scheme.

Complete Part 2 of this form if you are the referring medical practitioner or stomal therapy nurse.

Complete a duplicate form for each additional stoma.

Note: Part 1 and Part 2 must be completed.

For more information

For more information about the Stoma Appliance Scheme, go to our website **humanservices.gov.au** or if you need assistance completing this form, call **1800 700 270** Monday to Friday, between 8.30 am and 5.00 pm, Australian Eastern Standard Time.

Note: Call charges apply from mobile phones.

Filling in this form

- **Please use black or blue pen**
- Print in BLOCK LETTERS
- Mark boxes like this ☐ with a ✓ or ✗

Returning your form

Check that you have answered all the questions you need to answer and that you have signed and dated this form.

SEND THIS FORM TO YOUR NOMINATED STOMA ASSOCIATION FOR PATIENT REGISTRATION.

The nominated Stoma Association will send the completed form to:

Department of Human Services
Stoma Appliance Scheme
GPO Box 9826
HOBART TAS 7001

PART 1

Applicant's details

1 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name

First given name

Second given name

2 Date of birth

/ /

3 Address

Postcode

4 Medicare card number

– – Ref no.

or

Department of Veterans' Affairs card number

5 Stoma Appliance Scheme entitlement number (supplied by Stoma Association)

6 Type of Stoma

Tick ALL that apply

Permanent ☐ Temporary ☐

Colostomy ☐ Ileostomy ☐ Urostomy ☐

Other ☐ Give details below

Stoma association's details

7 Stoma association name

8 Stoma association address

Postcode

Applicant's authorisation

9 I hereby give authority for officers of the Australian Government Department of Human Services to:

- make enquiries about my use of medical or surgical aids, equipment or appliances.
- examine any medical or surgical aids, equipment or appliances supplied to me under the Commonwealth Stoma Appliance Scheme.

Applicant's signature

Date

/ /

Applicant's consent

The Australian Government Department of Human Services requires your consent to collect, access, use, disclose and record information:

- provided by you, **or**
- which is provided by your stomal therapy nurse/referring healthcare practitioner for the purposes of this application and the assessment of your eligibility to receive additional supplies under the Stoma Appliance Scheme.

Providing this consent means that you agree to the Australian Government Department of Human Services collecting, accessing, using, disclosing and recording information about you including information about:

- your health and any health services provided to you, **and**
- your use of medical or surgical aids, equipment or appliances.

The Australian Government Department of Human Services may provide this information to the Department of Health, your stomal therapy nurse/referring healthcare practitioner and your ostomy association for purposes related to any application under the Stoma Appliance Scheme (including an assessment of any application for stoma supplies).

You can revoke your consent at any time by advising the Australian Government Department of Human Services.

If you do not consent as requested below (or you withdraw your consent), your eligibility to receive additional supplies under the stoma appliance scheme cannot be assessed and you will not be able to receive additional supplies under the Stoma Appliance Scheme.

For more information about the way in which the department manages your personal information, visit the Your right to privacy page **humanservices.gov.au/customer/information/privacy** or see our privacy policy.

10 Do you consent to the Australian Government Department of Human Services collecting, accessing, using, disclosing and recording information about you related to the management of your stoma(s) for the purpose indicated above?

If you tick 'No', your eligibility to receive additional supplies under the Stoma Appliance Scheme cannot be assessed and you will not be able to receive additional supplies under the Stoma Appliance Scheme.

No ☐
Yes ☐

Applicant's signature

✍

Date

/ /

PART 2

Referring medical practitioner/stomal therapy nurse details

This part may only be completed by the referring medical practitioner or stomal therapy nurse. You must provide your provider number or Australian Health Practitioner Regulation Agency (AHPRA) registration number below.

11 Family name

First given name

12 Professional title

13 Referring practitioner number or AHPRA registration number

14 Practice location

Postcode

Privacy notice

15 Your personal information is protected by law, including the *Privacy Act 1988*, and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim.

Your information may be used by the department or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law.

You can get more information about the way in which the Department of Human Services will manage your personal information, including our privacy policy, at **humanservices.gov.au/privacy** or by requesting a copy from the department.

Declaration

16 **I declare that**:

- the information I have provided in this form is complete and correct.
- the applicant, named earlier in this form, is eligible to receive products under the Stoma Appliance Scheme as they do not have normal gastrointestinal tract and/or bladder function **and** have a temporary or permanent artificial body opening (whether surgically created or otherwise) which facilitates the removal of products of the gastrointestinal tract and/or urine.

I understand that:

- giving false or misleading information is a serious offence.

Referring medical practitioner's/stomal therapy nurse's signature

✍

Date

/ /

Reset form Print form