|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Barrier request form -** Please note that this form is used by all when requesting a barrier product not just for ONPOS, so please complete accordingly | | | | |
| **Barrier request form** | | | | |
| **Date:** |  | | | |
| **Patient name:** |  | | | |
| **Patient address:** |  | | | |
| **DOB:** |  | | | |
| **Telephone No:** |  | | | |
| **NHS number:** |  | | | |
| **Name of nurse (print)** |  | | | |
| **Nurse’s contact number:** |  | **Signature** |  | |
| **If supplied on FP10: Patient wishes the prescription to be:** | Left at the surgery for collection by patient or representative. | | |  |
| Forwarded to the pharmacy for collection by patient or carer. | | |  |
| Forwarded to the pharmacy for delivery to the patient. | | |  |
| **If supplied on FP10: Name and address of patient ‘s pharmacy** |  | | | |
| **Please note- if supplied via ONPOS pharmacy will not be able to deliver** | | | | |
| **NB. Products will only be supplied when information is provided on why there is a need to protect skin from moisture.** | | | | |

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| --- | --- | --- | --- | --- | --- | --- |
| **Is treatment required for longer than one month?** | Yes | No | If yes, please confirm who will review and date. This form is valid until that date (Cavilon only) | | | Date of review |
| To be reviewed by |
| **Has this product been ordered previously?** | Yes | No | If yes, when was this product last ordered (see care plan) | | |  |
| If use is continuous, has TVN advice been provided, if yes when and what was the outcome? | | | | Yes | No | Outcome: |

|  |  |  |
| --- | --- | --- |
| **Please confirm (tick box) which of the MASD or IAD criteria (see below) apply to this request and have been documented in patient notes** | | |
| At risk of skin damage as patient is incontinent. No redness and skin intact | |  |
| MILD skin damage. Red\* but skin intact | |  |
| MODERATE skin damage Red\* with skin breakdown | |  |
| SEVERE skin damage Red\* with skin breakdown | |  |
| Persistent diarrhoea | |  |
| \*Or paler, darker, purple, dark red or yellow in patients with darker skin tones | |  |
| **Drug Tariff Specification** | **Quantity requested\*** | |
| **Cavilon Durable Barrier Cream 28g**  On average this product size will last one week |  | |
| **Cavilon Durable Barrier Cream 92g** On average this product size will last 3-4 weeks |  | |
| **Cavilon No-Sting Barrier Film Pump Spray 28ml**  Apply every 24 hours although frequency can be reduced to 48–72 hours in line with skin improvement. |  | |
| **Cavilon No-Sting Barrier Film Foam Applicators 5x1ml**  Apply every 24 hours although frequency can be reduced to 48–72 hours in line with skin improvement. |  | |
| **Proshield Plus skin protective 115g** Only for use where SEVERE skin damage |  | |
| **Proshield Foam & Spray skin cleanser 235ml** Only for patients with moisture lesions and SEVERE diarrhoea. |  | |
| **\*For each product, only 1 pack can be requested. If additional packs are needed further information must be provided** | | |
| Moisture Associated Skin damage (MASD) Pathway A **http://flo/Interact/Pages/Content/Document.aspx?id=6919**  Incontinence Associated Dermatitis (IAD) Pathway B <http://flo/Interact/Pages/Content/Document.aspx?id=6918> | | |