



**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 a patient fits the criteria below they must be assessed by a Stomal Therapy Nurse (STN), Nurse Practitioner, Registered Nurse, or a Registered Medical Professional, in order to rule out other underlying problems.

**Criteria:**

- patient must have high liquid output.

**Authorisation Form**

I..... give  
(Full Name of Stomal Therapy Nurse (STN)/ Nurse Practitioner/ Registered Nurse, or Registered Medical Professional)

Patient name .....

Authority to order the Deodorant and Absorption Gelling Sachets from their Stoma Association.

*The above mentioned patient has received education from me and has agreed to return for a review within six months of initial consultation.*

Stomal Therapy Nurse (STN)/ Nurse Practitioner/ Registered Nurse, or Registered Medical Professional's Signature .....

Patient's signature .....

Date .....

**Note: *The above must be ordered within two months of application issue date***

**STOMA ASSOCIATION**

Patient's name .....

Patient membership number .....

Signature of distribution person .....

Date .....