# AUSTRALIAN ASSOCIATION OF STOMAL THERAPY NURSES INC.

**ABN 16 072 891 322**

## Irrigation Kit Authorisation Form

| **Authorisation Form** |
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| I…… give<br>(Full Name of Stomal Therapy Nurse (STN)/ Nurse Practitioner/ Registered Nurse, or Registered Medical Professional)<br><br>Patient name ……<br><br>Authority to collect and initial irrigation kit / conseal plugs (circle relevant item) from their Ostomy Association.<br><br>*The above mentioned patient has received education from me or has agreed to return to me for education and training on irrigation or use of conseal plug before attempting to use these items.*<br><br>*I have consulted with the relevant surgeon who agrees that irrigation is appropriate for this patient.*<br><br>Stomal Therapy Nurse (STN)/ Nurse Practitioner/ Registered Nurse, or<br>Registered Medical Professional's Signature ……<br>Patient's signature ……<br>Date ……..<br><br>**THIS AUTHORISATION IS VALID FOR 12 MONTHS ONLY**<br><br>**Note:** ***The above must be ordered within two months of application issue date*** |

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## OSTOMY ASSOCIATION

Patient's name ……....

Patient membership number ……..

Signature of distribution person …….

Date ……....