CONFIDENTIAL

ALTERATION FORM

email: alteration@secondskin.com.au

PATIENT DETAILS		**Date:**	
Patient: (Surname)		**Given Name:**	
Preferred Name:		**DOB:**	

HOSPITAL / CENTRE			
Therapist Name:		**Department:**	
Therapist Phone No:		**Pager No:**	
Therapist Email:			
Photos Sent via:	Online portal (preferred) ◯	Email ◯	Unable to provide ◯
	(Show area of concern; front, side and back views; marked up garment; pinching out for retension)		

FUNDING BODY			
Company:		**Company Email:**	
Case Manager:		**Case Mgr Email:**	
Claim No:		**Phone No:**	

GARMENT/S	
What are you seeing	
Details: Alt required	

Email quote to:		**Cc Email:**	
Email invoice to:		**PO No:**	
Shipping details:	Therapist address as previous ◯	Patient address as previous ◯	
Or Other:			
Date required by:	or standard turn around, 10 working days*		

***Second Skin will always endeavor to supply this order by the date you require.**
Please keep in mind that delivery is subject to freight times and the receipt of written funding approval/hospital orders.