Prescription Request for Consideration of Adult Oral Nutritional Supplements

This form must be completed by a care home. It requests the information needed so that the GP can decide whether the prescription is appropriate.

Complete this form if this is a new request

Date:
Care Home:
Address: **Contact Tel**:
Patient Name:
Date of Birth:
NHS Number:

Weight History: *(if you can't convert, give in stones and pounds)*	
Current weight (kg):	Date:
Weight last month (kg):	Date:
Weight last 3-6 months (kg):	Date:

Height (m):	**Current BMI:**

MUST Scores:	
Current MUST score:	Date:
MUST score last month:	Date:

Why are you requesting the prescription? *Please indicate the reason(s) that apply:*

Weight Loss: Yes/No

Pressure Sore Grade 3 or More/ or Chronic Wound: Yes/No

Completed food record charts show that the patient has a poor appetite/poor oral intake ☐

(Please tick - please don't send the charts with this form but do ensure they are available for the GP to view if requested)

Has *Food First* been trialled for at least a month?

I confirm that the patient is on a high calorie diet, is being offered extra snacks in between meals and the meals and snacks provided are being fortified but this alone has not resulted in any improvement in their weight or oral intake. **Yes/No** (*Please indicate*)

Any other Information (e.g. *state here if too unwell to be weighed and why*) **:**

Signed on behalf of care home: _____

Print name: _____

Position (Please state your job e.g. manager/carer/nutrition champion): _____

Office Use: Ensure that this form is scanned on to SystmOne and MUST scores & weights are recorded