<u>Repeat</u> Prescription Request for 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 <u>repeat</u> request

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

Name of oral nutritional supplement	**How many is the patient prescribed daily?**

Weight History: *(if you can't convert, give in stones and pounds)*	
Current weight (kg):	Date:
Weight last month (kg):	Date:
Please state reason if unable to weigh:	

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

Is the patient currently being seen by a dietitian? **Yes/No** *(Please indicate)*

Declaration

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

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

Please only complete this box if you think that the patient needs a review of their oral nutritional supplement prescription

Please indicate why you think that the patient needs a review of their supplement prescription (e.g. they are refusing them/gaining weight/struggling to take the supplement at the prescribed dose):

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 onto SystmOne and MUST scores & weights are recorded