Community Pharmacy Nutrition Support Service
ONS Dietetic Request to Community Pharmacy

N.B. Community pharmacy – please ensure that all patients have completed a service registration form

Request to Community Pharmacy

Pharmacy Name: Westeros Pharmacy
Address The Eyrie
Westeros
W12 LFS

Patient name: JOHN SNOW
CHI: 12345 67891
Address: 1 Winterfell
Westeros
W12 OER

Tel no: 07825 37434
Guardian/carer name and tel no. if appropriate:

Following a dietetic consultation this patient has agreed to take the ONS products listed below in addition to diet and fluids for the following ACBS indication(s):

Please tick

- ❑ Short bowel syndrome /
- ❑ Dysphagia
- ❑ Intractable malabsorption
- ❑ Other_____
- ❑ Pre-operative preparation of undernourished patients
- ❑ Inflammatory bowel disease
- ❑ Total gastrectomy
- ❑ Bowel fistulae
- ❑ **Disease related malnutrition**

- ❑ **This is a new prescription for ONS**
- ❑ This patient already uses the service; this is a prescription amendment. Please discontinue prescriptions for any products not listed below.

Follow up and ONS monitoring will be undertaken by:

Please tick one

- ❑ **Myself / my dietetic team**
- ❑ The following dietetic team (name, address and contact details)_____
  _____
- ❑ Community pharmacy (ONS monitoring transfer form or letter attached / to follow)
- ❑ Other: _____(name, designation, address and contact details) will keep you informed of any changes to the patient's product requirements. Please continue to prescribe and dispense ONS for this patient.
- ❑ No follow up - this patient requires 4 weeks supply of ONS only post hospital discharge (see care pathway)
- ❑ No follow up - this patient requires ONS to be prescribed and dispensed without monitoring for the duration indicated (no longer than 6 months) for the following reason:
  (Please tick) End of life care ☐ Complex condition ☐ Condition requiring intermittent ONS use ☐

Dietitian to please score through / delete products not required			
PRODUCT NAME	**DOSE**	**FLAVOURS / other directions**	**DURATION ***
Ensure Shake	_**1**__x 57g sachet per **day**	**Various**	**Ongoing**
Ensure Plus Milkshake Style	___x 200ml bottle per___		
Ensure Compact	___x 125ml bottle per___		
Fortisip Compact (Neutral only)	___x 125ml bottle per____	Neutral only	
Ensure Plus Juce Style	___x 220ml bottle per___		
Ensure Plus Yoghurt Style	___x 200ml bottle per___		
Fresubin 3.2 kcal	___x 125ml bottle per___		
Other:			
If **non-formulary** product, justification for product selection:			

*If 'ongoing' prescribe every 28/31 days until further instruction received from dietitian (usually within 3 months)

Dietitian:_____A Stark_____HCPC no: DT12345_____Date: 01/01/1983
(print name and sign)

Dietetic Team and contact details:___Dietetics Department, Riverrun, 01256 852 252 _____(N.B. This team can be contacted for information relating to the requested **product.** For information regarding the patient's future **care** please contact the person responsible for follow up as outlined in the shaded box above)

SAMPLE