**Care Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unit / Floor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2 Week Oral Nutritional Supplement Order Form for Care Homes**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Fax / Send to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ pharmacy**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Name  & CHI  (e.g. “Joe Bloggs  0101010101”) | Product and daily recommended dose  (e.g. “1 x Ensure Shake sachet”) | No. required for 14 days  e.g. 14 | Current Stock  7 | No. required to be prescribed  7 (1 box) | Weight (kg) and date recorded | Height (m) | BMI (kg/m2) | MUST score | Dietitian monitoring plan and targets | Likes and Dislikes |
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