Community Pharmacy Nutrition Support Service
Oral Nutritional Supplement (ONS) monitoring transfer form

NHS Greater Glasgow and Clyde

Request to Community Pharmacy Pharmacy Name: Address:	Patient name: CHI: Address: Tel no: Guardian/carer name and tel no. if appropriate:

Dear pharmacy colleague,

This patient's dietetic treatment is now complete and no further dietetic follow up is planned. The patient continues to require ONS, in line with the agreed aim of nutritional treatment, nutritional goals and targets.

I would be grateful if you would continue to prescribe and supply ONS for this patient AND monitor the ongoing need for ONS by assessing this patient monthly and amending their ONS prescription as detailed in the table below:

Instructions to community pharmacy for ONS monitoring

Monitoring should be completed with:

- The patient
- Carer/guardian (as detailed above)
- Other (provide name, relationship to patient and contact details):

In the following setting:

- This person will attend the pharmacy to complete reviews
- Please phone this person to complete reviews

Using:

- Measured / reported weights
- Subjective Assessment Questions

	Height (M):		Weight (kg)	BMI (kg/m^2)	MUST score	When Subjective Assessment indicates:
ONS can be reduced to _____ units per day at the following targets →						
ONS can be further reduced to _____ units per day at the following targets →						
ONS can be discontinued at the following targets → **OR** if weight/BMI is maintained at _____ for a period of ____ month(s)						
The patient should be re-referred to the dietetic service if the patient declines to the following weight / BMI / MUST score →						

Additional relevant information:

Dietitian: _____ HCPC no: _____ Date: _____
(print name and sign)

Dietetic Team and contact details:_____