Oral nutritional supplement (ONS) prescription request

Please ensure the 6 steps to appropriate prescribing of oral nutritional supplement (ONS) in adults guidance has been followed before requesting ONS.

Patient name: Click here to enter text.

Date of birth: Click here to enter text.

NHS number: Click here to enter text.

| **Product information** | **Product 1** | **Product 2** |
| --- | --- | --- |
| Product name  | Click here to enter text. | Click here to enter text. |
| Dose | Click here to enter text. | Click here to enter text. |
| Frequency | Click here to enter text. | Click here to enter text. |
| Amount for 28 days: | Click here to enter text. | Click here to enter text. |
| Number of weeks prescription required: | Click here to enter text. | Click here to enter text. |
| Flavours (max 3 per patient): | Click here to enter text. | Click here to enter text. |

See primary care [ONS formulary](https://www.eclipsesolutions.org/UploadedFiles/509_2020%20ONS%20Quick%20reference%20formulary.pdf)

If not requesting first-line Foodlink Complete or second-line Aymes Complete please provide reason for alternative ONS:

Click here to enter text.

ACBS indication (see [Part XV of the Drug Tariff](https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/drug-tariff)): Click here to enter text.

Goal of ONS prescription: Click here to enter text.

Plan for review (when and by whom): Click here to enter text.

| **Date** | **Weight (kg)** | **BMI (kg/m2)** | **Weight change last 3 months** | **MUST score** |
| --- | --- | --- | --- | --- |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

# Additional information

Click here to enter text.

# Healthcare professional contact details

Name: Click here to enter text.

Telephone: Click here to enter text.

Email: Click here to enter text.