Gluten Free Food Requirements
Patient Monthly Order Form

Patient Name: _ Date: _ _ _ _ _ _ _ _ _ _ _ _ _

Patient NHS No: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Maximum no of units per month allowed: _ _ _ _ _ _ _

Only products listed in the Drug Tariff are allowable

Product	Type	Pack Size	Brand	Units/ Item	Quantity	Total No. of units supplied
e.g. BREAD	*white unsliced*	*1*	*Juvela*	*1*	*4*	*4*
BREAD						
BREAD ROLLS						
MIXES						
PASTA						
PIZZA BASES						
BISCUITS						
CRACKERS						
CRISP BREADS						
XANTHAN						

	Yes / No		
Prescription charge paid :			
Prepaid certificate :		***Expiry date:***	

To the Patient: Please sign for receipt of your order

Patient signature………………………………………………..Date:……………

To the Pharmacist: Please ensure that this form is completed full for each patient including a patient signature for receipt of goods. The form must be retained in the pharmacy and may be requested by the PCT for audit purposes. Remuneration for gluten free products will be made according to the Chemist & Druggist prices.

Pharmacy Stamp: