

## Appendix 2

# Gluten-Free Food Requirement Order Form



Patient Name	Date of Birth
Address	Tel No.
	Date
	Units allowed for month

Please write below the items you wish to order

Manufacturer/Description	PIP Code	Unit Size	Quantity	Total Units
<i>Example - Glutafin Fibre Loaf Sliced</i>	<i>237 7356</i>	<i>400g</i>	<i>6</i>	<i>6</i>
<b>Total units</b>				

**Hand this form to your community pharmacy to place your order**  
 If you wish to keep a copy for your records please use a spare form or ask if your pharmacist can copy it for you.

Pharmacy Use: This form should be kept in the pharmacy for 12 months