Gluten-Free Food Requirement
Order Form

NHS SCOTLAND

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
			Total units	

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