United Republic of Tanzania

Ministry of Health, Community Development, Gender, Elderly and Children

NACS Record No. [__][__][__][__]

Specialised Food Product Prescription Form

Region _____ District_____ Facility name_____ Facility code _____

Client name _____

Client number[1] _____ Sex *(tick one ☑)*: ☐M ☐F

Age (years) _____ Child < 5 (months) _____

Client category	Reason *(Tick one or more where applicable)* ☑			No. of units prescribed/day				No. of days	No. of units dispensed
	SAM	MAM	Normal	F-75 (102.5 g packet)	F-100 (114.0 g packet)	RUTF (92.0 g packet)	FBF (4.5 kg bag)		
0–6 months									
7–11 months									
12–23 months									
24–59 months									
5–< 15 years									
15–< 18 years									
18+ years									
Pregnant/≤ 6 months post-partum									
Total									

Prescriber: Name _____ Signature _____ Date: _____

Dispenser: Name _____ Signature _____ Date: _____

[1] Use CTC number; if client is referred from another service, use that service's file number.