

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to [Section H](#) of the Pharmaceutical Schedule. For community funding, see the [Special Authority Criteria](#).

PRESCRIBER

PATIENT:

Name:

Name:

Ward:

NHI:

High Calorie Products

INITIATION

Prerequisites (tick boxes where appropriate)

Patient is fluid volume or rate restricted

or

Patient requires low electrolyte

or

Cystic fibrosis

or

Any condition causing malabsorption

or

Faltering growth in an infant/child

or

Increased nutritional requirements

and

Patient has substantially increased metabolic requirements

I confirm that the above details are correct:

Signed: Date: