HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

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

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Diabetic Products

INITIATION

Prerequisites (tick boxes where appropriate)

- ○ For patients with type I or type II diabetes suffering weight loss and malnutrition that requires nutritional support

or

- ○ For patients with pancreatic insufficiency

or

- ○ For patients who have, or are expected to, eat little or nothing for 5 days

or

- ○ For patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism

or

- ○ For use pre- and post-surgery

or

- ○ For patients being tube-fed

or

- ○ For tube-feeding as a transition from intravenous nutrition

I confirm that the above details are correct:

Signed: ..... Date: .....