

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: .....