

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: .....

**Protein**

**INITIATION – Use as an additive**

**Prerequisites** (tick boxes where appropriate)

- ☐ Protein losing enteropathy
- or
- ☐ High protein needs

**INITIATION – Use as a module**

**Prerequisites** (tick box where appropriate)

- ☐ For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk.

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

I confirm that the above details are correct:

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