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: .....

Paediatric Products

INITIATION

Prerequisites (tick boxes where appropriate)

- ○ Child is aged one to ten years

and

- ○ The child is being fed via a tube or a tube is to be inserted for the purposes of feeding

or

- ○ Any condition causing malabsorption

or

- ○ Faltering growth in an infant/child

or

- ○ Increased nutritional requirements

or

- ○ The child is being transitioned from TPN or tube feeding to oral feeding

or

- ○ The child has eaten, or is expected to eat, little or nothing for 3 days

HOSPITAL

I confirm that the above details are correct:

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