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: .....

Standard Feeds

INITIATION

Prerequisites (tick boxes where appropriate)

For patients with malnutrition, defined as any of the following:

- ○ BMI < 18.5

or

- ○ Greater than 10% weight loss in the last 3-6 months

or

- ○ BMI < 20 with greater than 5% weight loss in the last 3-6 months

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

or

○ For any other condition that meets the community Special Authority criteria

I confirm that the above details are correct:

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