Form RS1215
July 2024

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

HOSPITAL

I confirm that the above details are correct:

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