

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: .....

**High protein enteral feed**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

- The patient has a high protein requirement
- and**
- Patient has liver disease
- or**
- Patient is obese (BMI > 30) and is undergoing surgery
- or**
- Patient is fluid restricted
- or**
- Patient's needs cannot be more appropriately met using high calorie product

I confirm that the above details are correct:

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