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: .....

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: .....