HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 1

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				PATIENT:
Name:				Name:
Ward:				NHI:
Diabe	etic	Pro	ducts	
INITIA Prere			(tick boxes where appropriate)	
	or	\sim	For patients with type I or type II diabetes suffering weight loss	and malnutrition that requires nutritional support
	or	\bigcirc	For patients with pancreatic insufficiency	for E days
	or	\sim	For patients who have, or are expected to, eat little or nothing. For patients who have a poor absorptive capacity and/or high	nutrient losses and/or increased nutritional needs from causes such as
	or	\bigcirc	catabolism For use pre- and post-surgery	
	or	\circ	For patients being tube-fed	
	or	0	For tube-feeding as a transition from intravenous nutrition	

I confirm that the above details are correct:	
Cimadi	Data