I confirm that the above details are correct:

Signed: Date:

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		PATIENT:
Name:		Name:
Ward:		NHI:
Fat		
	Use as an additive s (tick boxes where appropriate)	
or O	Patient has inborn errors of metabolism Faltering growth in an infant/child Bronchopulmonary dysplasia Fat malabsorption Lymphangiectasia Short bowel syndrome Infants with necrotising enterocolitis Biliary atresia For use in a ketogenic diet Chyle leak Ascites	
or O	Patient has increased energy requirements, and for v	whom dietary measures have not been successful
Prerequisites For u	Use as a module s (tick box where appropriate) use as a component in a modular formula made from a Pharmaceutical Schedule or breast milk. s are required to meet any Special Authority criteria ass	at least one nutrient module and at least one further product listed in Section D of sociated with all of the products used in the modular formula.