

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: .....

**Carbohydrate and fat supplement**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

Infant or child aged four years or under

**and**

Cystic fibrosis

**or**

Cancer in children

**or**

Faltering growth

**or**

Bronchopulmonary dysplasia

**or**

Premature and post premature infants

I confirm that the above details are correct:

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