HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:
Standard Feeds	

Prerequisites (tick boxes where appropriate)				
	For patients with malnutrition, defined as any of the following:			
		O BMI < 18.5		
	or	O Greater than 10% weight loss in the last 3-6 months		
	or	O BMI < 20 with greater than 5% weight loss in the last 3-6 months		
or				
or	\bigcirc	For patients who have, or are expected to, eat little or nothing for 5 days		
or	Ο	For patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism		
or	Ο	For use pre- and post-surgery		
or	\cap			
or	\bigcirc	For patients being tube-fed		
	Ο	For tube-feeding as a transition from intravenous nutrition		
or	0	For any other condition that meets the community Special Authority criteria		

I confirm that the above details are correct: