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:	
Diabetic Products					
INITIATION Prerequisites (tick boxes where appropriate)					
	or (O O O O	For patients with type I or type II diabetes suffering weight loss at For patients with pancreatic insufficiency For patients who have, or are expected to, eat little or nothing for patients who have a poor absorptive capacity and/or high necatabolism For use pre- and post-surgery		
	or	O O	For patients being tube-fed For tube-feeding as a transition from intravenous nutrition		

I confirm that the above details are correct:	
Cianad	Data