## 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:

## **Paediatric Products**

( and	С	Chilo	I is aged one to ten years
anu		Ο	The child is being fed via a tube or a tube is to be inserted for the purposes of feeding
	or	0	Any condition causing malabsorption
	or	0	Faltering growth in an infant/child
	or	0	Increased nutritional requirements
	or	0	The child is being transitioned from TPN or tube feeding to oral feeding
	or	$\bigcirc$	The child has eaten, or is expected to eat, little or nothing for 3 days