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

| ITIATION rerequisites (tick boxes where appropriate) | | | |
|---|----|-------|---|
| (and | С | Chilc | I is aged one to ten years |
| | or | Ο | The child is being fed via a tube or a tube is to be inserted for the purposes of feeding |
| | | Ο | Any condition causing malabsorption |
| | or | Ο | Faltering growth in an infant/child |
| | or | Ο | Increased nutritional requirements |
| | or | 0 | The child is being transitioned from TPN or tube feeding to oral feeding |
| | or | 0 | The child has eaten, or is expected to eat, little or nothing for 3 days |
| | | | |

I confirm that the above details are correct: