

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:

High protein enteral feed

INITIATION

Prerequisites (tick boxes where appropriate)

☐ The patient has a high protein requirement
and

☐ Patient has liver disease

or
☐ Patient is obese (BMI > 30) and is undergoing surgery

or
☐ Patient is fluid restricted

or
☐ Patient's needs cannot be more appropriately met using high calorie product

I confirm that the above details are correct:

Signed: Date: