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.

Schedule. For community funding, see the Special Authority Criteria.	
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Carbohydrate	
INITIATION – Use as an additive Prerequisites (tick boxes where appropriate)	
O Cystic fibrosis	
Chronic kidney disease	
O Cancer in children	
Cancers affecting alimentary tract where there are malabs	sorption problems in patients over the age of 20 years
Faltering growth in an infant/child	
Or Bronchopulmonary dysplasia	
O Premature and post premature infant	
O Inborn errors of metabolism	
INITIATION – Use as a module Prerequisites (tick box where appropriate)	
O For use as a component in a modular formula made from at least the Pharmaceutical Schedule or breast milk Note: Patients are required to meet any Special Authority criteria associa	st one nutrient module and at least one further product listed in Section D of ted with all of the products used in the modular formula.

I confirm that the above details are correct:

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