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

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

High arginine oral feed 1.4 kcal/ml

INITIATION

Prerequisites (tick box where appropriate)

- ○ Three packs per day for 5 to 7 days prior to major gastrointestinal, head or neck surgery

I confirm that the above details are correct:

Signed: ..... Date: .....