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: .....

Carbohydrate

INITIATION – Use as an additive

Prerequisites (tick boxes where appropriate)

- ○ Cystic fibrosis

or

- ○ Chronic kidney disease

or

- ○ Cancer in children

or

- ○ Cancers affecting alimentary tract where there are malabsorption problems in patients over the age of 20 years

or

- ○ Faltering growth in an infant/child

or

- ○ Bronchopulmonary dysplasia

or

- ○ Premature and post premature infant

or

- ○ Inborn errors of metabolism

INITIATION – Use as a module

Prerequisites (tick box where appropriate)

- ○ For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

I confirm that the above details are correct:

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