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: .....

Fat-modified feed

INITIATION

Prerequisites (tick boxes where appropriate)

- ○ Patient has metabolic disorders of fat metabolism

or

- ○ Patient has a chyle leak

or

- ○ Modified as a modular feed, made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule, for adults

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: .....