## 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	PATIENT:
Name:	Name:
Ward:	NHI:
Paediatric Products	
INITIATION Prerequisites (tick boxes where appropriate)  Child is aged one to ten years and  The child is being fed via a tube or a tube is to be inserted or Any condition causing malabsorption or Faltering growth in an infant/child or Increased nutritional requirements or The child is being transitioned from TPN or tube feeding or	to oral feeding
The child has eaten, or is expected to eat, little or nothin	g for 3 days

I confirm that the above details are correct:	
Signed:	Date: