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: .....

Paediatric oral/enteral feed 1 kcal/ml

INITIATION – Fluid restricted or volume intolerance with faltering growth

Prerequisites (tick boxes where appropriate)

- ❍ The patient is fluid restricted or volume intolerant

or

- ❍ The patient has increased nutritional requirements due to faltering growth

and

- ❍ Patient is under 18 months old and weighs less than 8kg

Note: 'Volume intolerant' patients are those who are unable to tolerate an adequate volume of infant formula to achieve expected growth rate. These patients should have first trialled appropriate clinical alternative treatments, such as concentrating, fortifying and adjusting the frequency of feeding.

I confirm that the above details are correct:

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