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.

PRESCR	IBER	PATIENT:
Name: .		
Ward:		NHI:
Standa	rd Fe	eeds
INITIATI Prerequ		(tick boxes where appropriate)
	For	patients with malnutrition, defined as any of the following:
		O BMI < 18.5
	ıo	O Greater than 10% weight loss in the last 3-6 months
	10	BMI < 20 with greater than 5% weight loss in the last 3-6 months
or	0	For patients who have, or are expected to, eat little or nothing for 5 days
or	0	For patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism
or	\circ	For use pre- and post-surgery
or	\circ	For patients being tube-fed
or	\circ	For tube-feeding as a transition from intravenous nutrition
or	0	For any other condition that meets the community Special Authority criteria

I confirm that the above details are correct:

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