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: .....

Elemental and Semi-Elemental Products

INITIATION

Prerequisites (tick boxes where appropriate)

- ○ Malabsorption

or

- ○ Short bowel syndrome

or

- ○ Enterocutaneous fistulas

or

- ○ Eosinophilic enteritis (including oesophagitis)

or

- ○ Inflammatory bowel disease

or

- ○ Acute pancreatitis where standard feeds are not tolerated

or

- ○ Patients with multiple food allergies requiring enteral feeding

I confirm that the above details are correct:

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