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: .....

High protein enteral feed

INITIATION

Prerequisites (tick boxes where appropriate)

- ○ The patient has a high protein requirement

and

- ○ Patient has liver disease

or

- ○ Patient is obese (BMI > 30) and is undergoing surgery

or

- ○ Patient is fluid restricted

or

- ○ Patient's needs cannot be more appropriately met using high calorie product

I confirm that the above details are correct:

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