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:	
Standaı	d Fe	eds	
INITIATIO Prerequi		(tick boxes where appropriate)	
For patients with malnutrition, defined as any of the following:			
		O BMI < 18.5	
	or	O Greater than 10% weight loss in the last 3-6 months	
	or	O 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	0	For patients being tube-fed	
or	0	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:	
Signed:	Date: