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				PATIENT:
Name:				Name:
Ward:				NHI:
Elemental and Semi-Elemental Products				
	INITIATION Prerequisites (tick boxes where appropriate)			
	or or or or or	O O O	Malabsorption Short bowel syndrome Enterocutaneous fistulas	
		0 0	Eosinophilic enteritis (including oesophagitis) Inflammatory bowel disease Acute pancreatitis where standard feeds are not tolerated Patients with multiple food allergies requiring enteral feeding	