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:
High protein enteral feed	
INITIATION Prerequisites (tick boxes where appropriate) The patient has a high protein require and Patient has liver disease or Patient is obese (BMI > 30) and or Patient is fluid restricted or Patient's needs cannot be more	