

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:

Paediatric Products

INITIATION

Prerequisites (tick boxes where appropriate)

- ☐ Child is aged one to ten years
and
- ☐ The child is being fed via a tube or a tube is to be inserted for the purposes of feeding
or
☐ Any condition causing malabsorption
or
☐ Faltering growth in an infant/child
or
☐ Increased nutritional requirements
or
☐ The child is being transitioned from TPN or tube feeding to oral feeding
or
☐ The child has eaten, or is expected to eat, little or nothing for 3 days

I confirm that the above details are correct:

Signed: Date: