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:	
Multivitamins - Cap					
INITIATION Prerequisites (tick boxes where appropriate)					
		0	Patient has cystic fibrosis with pancreatic insufficiency		
	or	0	Patient is an infant or child with liver disease or short gut synd	rome	
	or	0	Patient has severe malabsorption syndrome		