

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:

Elemental and Semi-Elemental Products

INITIATION

Prerequisites (tick boxes where appropriate)

- ☐ Malabsorption
or
☐ Short bowel syndrome
or
☐ Enterocutaneous fistulas
or
☐ Eosinophilic enteritis (including oesophagitis)
or
☐ Inflammatory bowel disease
or
☐ Acute pancreatitis where standard feeds are not tolerated
or
☐ Patients with multiple food allergies requiring enteral feeding

I confirm that the above details are correct:

Signed: Date: