

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: NHI:

High Calorie Products

INITIATION

Prerequisites (tick boxes where appropriate)

- Patient is fluid volume or rate restricted
- or Patient requires low electrolyte
- or
 - Cystic fibrosis
 - or Any condition causing malabsorption
 - or Faltering growth in an infant/child
 - or Increased nutritional requirements
- and Patient has substantially increased metabolic requirements

I confirm that the above details are correct:

Signed: Date: