

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: .....

**High arginine oral feed 1.4 kcal/ml**

**INITIATION**

**Prerequisites** (tick box where appropriate)

- Three packs per day for 5 to 7 days prior to major gastrointestinal, head or neck surgery

HOSPITAL

I confirm that the above details are correct:

Signed: ..... Date: .....