

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: