HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

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 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

HOSPITAL

I confirm that the above details are correct:

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