

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: .....

**Paediatric Products**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

Child is aged one to ten years

and

The child is being fed via a tube or a tube is to be inserted for the purposes of feeding

or

Any condition causing malabsorption

or

Faltering growth in an infant/child

or

Increased nutritional requirements

or

The child is being transitioned from TPN or tube feeding to oral feeding

or

The child has eaten, or is expected to eat, little or nothing for 3 days

I confirm that the above details are correct:

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