

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:

Carbohydrate and fat supplement

INITIATION

Prerequisites (tick boxes where appropriate)

Infant or child aged four years or under

and

Cystic fibrosis

or

Cancer in children

or

Faltering growth

or

Bronchopulmonary dysplasia

or

Premature and post premature infants

I confirm that the above details are correct:

Signed: Date: