

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:

Low electrolyte oral feed

INITIATION

Prerequisites (tick box where appropriate)

For patients with acute or chronic kidney disease

HOSPITAL

I confirm that the above details are correct:

Signed: Date: