

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**

**PATIENT:**

Name: .....

Name: .....

Ward: .....

NHI: .....

**Carbohydrate**

**INITIATION – Use as an additive**

**Prerequisites** (tick boxes where appropriate)

- Cystic fibrosis
- or  Chronic kidney disease
- or  Cancer in children
- or  Cancers affecting alimentary tract where there are malabsorption problems in patients over the age of 20 years
- or  Faltering growth in an infant/child
- or  Bronchopulmonary dysplasia
- or  Premature and post premature infant
- or  Inborn errors of metabolism

**INITIATION – Use as a module**

**Prerequisites** (tick box where appropriate)

- For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

I confirm that the above details are correct:

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