

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: .....

**Standard Feeds**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

**For patients with malnutrition, defined as any of the following:**

- BMI < 18.5
- or
- Greater than 10% weight loss in the last 3-6 months
- or
- BMI < 20 with greater than 5% weight loss in the last 3-6 months

- or
- For patients who have, or are expected to, eat little or nothing for 5 days
- or
- For patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism
- or
- For use pre- and post-surgery
- or
- For patients being tube-fed
- or
- For tube-feeding as a transition from intravenous nutrition
- or
- For any other condition that meets the community Special Authority criteria

I confirm that the above details are correct:

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