HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

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: ....

High fat formula

INITIATION

Prerequisites (tick box where appropriate)

❍ For patients with intractable epilepsy, pyruvate dehydrogenase deficiency or glucose transported type-1 deficiency and other conditions requiring a ketogenic diet

HOSPITAL

I confirm that the above details are correct:

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