

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: