

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: .....

**Diabetic Products**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

- ☐ For patients with type I or type II diabetes suffering weight loss and malnutrition that requires nutritional support
- or
- ☐ For patients with pancreatic insufficiency
- 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

I confirm that the above details are correct:

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