

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:

Nicotine

INITIATION

Prerequisites (tick boxes where appropriate)

- For perioperative use in patients who have a 'nil by mouth' instruction

or

- For use within mental health inpatient units

or

- Patient would be admitted to a mental health inpatient unit, but is unable to due to COVID-19 self-isolation requirement

or

- For acute use in agitated patients who are unable to leave the hospital facilities

I confirm that the above details are correct:

Signed: Date: