Form RS1133
April 2024

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: ....

Potassium citrate

INITIATION
Prerequisites (tick boxes where appropriate)

○ The patient has recurrent calcium oxalate urolithiasis

and

○ The patient has had more than two renal calculi in the two years prior to the application

HOSPITAL

I confirm that the above details are correct:

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