

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: .....

**Bacillus calmette-guerin vaccine**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

**For infants at increased risk of tuberculosis defined as:**

- ☐ Living in a house or family with a person with current or past history of TB
- and**
- ☐ Having one or more household members or carers who within the last 5 years lived in a country with a rate of TB > or equal to 40 per 100,000 for 6 months or longer
- and**
- ☐ During their first 5 years will be living 3 months or longer in a country with a rate of TB > or equal to 40 per 100,000

Note: A list of countries with high rates of TB are available at <http://www.health.govt.nz/tuberculosis> (Search for Downloads) or [www.bcgatlas.org/index.php](http://www.bcgatlas.org/index.php)

I confirm that the above details are correct:

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