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.

		PATIENT:		
Name:		Name:		
Re-assessmer	primary vaccinations nt required after 1 dose (tick boxes where appropriate)			
or O	Any infant born on or after 1 April 2016  For previously unvaccinated children turning 11 years old or (chickenpox)	or after 1 July 2017, who have not previously had a varicella infection		
Re-assessmer	other conditions nt required after 2 doses (tick boxes where appropriate)			
or	O With deteriorating renal function before transplantation			
or	O Prior to any elective immunosuppression*	etent inpatients		

I confirm that the above details are correct:

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