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: .....

Rotavirus oral vaccine

INITIATION
Re-assessment required after 2 doses
Prerequisites (tick boxes where appropriate)

- ○ First dose to be administered in infants aged under 14 weeks of age

and

- ○ No vaccination being administered to children aged 24 weeks or over

HOSPITAL

I confirm that the above details are correct:

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