# 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: .....

## 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: .....