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: .....

Hyoscine hydrobromide - Patch 1.5 mg

INITIATION

Prerequisites (tick boxes where appropriate)

- ❍ Control of intractable nausea, vomiting, or inability to swallow saliva in the treatment of malignancy or chronic disease where the patient cannot tolerate or does not adequately respond to oral anti-nausea agents

or

- ❍ Control of clozapine-induced hypersalivation where trials of at least two other alternative treatments have proven ineffective

or

- ❍ For treatment of post-operative nausea and vomiting where cyclizine, droperidol and a 5HT3 antagonist have proven ineffective, are not tolerated or are contraindicated

I confirm that the above details are correct:

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