

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: .....

**Methoxyflurane**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

- Patient is undergoing a painful procedure with an expected duration of less than one hour  
**and**  
 Only to be used under supervision by a medical practitioner or nurse who is trained in the use of methoxyflurane

HOSPITAL

I confirm that the above details are correct:

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