

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: .....