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: .....

Measles, mumps and rubella vaccine

INITIATION – first dose prior to 12 months
Re-assessment required after 3 doses
Prerequisites (tick boxes where appropriate)

- ○ For primary vaccination in children

or

- ○ For revaccination following immunosuppression

or

- ○ For any individual susceptible to measles, mumps or rubella

INITIATION – first dose after 12 months
Re-assessment required after 2 doses
Prerequisites (tick boxes where appropriate)

- ○ For primary vaccination in children

or

- ○ For revaccination following immunosuppression

or

- ○ For any individual susceptible to measles, mumps or rubella

Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.

HOSPITAL

I confirm that the above details are correct:

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