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.

PRES	CRI	BER							PATIENT:
Name	e:								Name:
Ward	:								NHI:
Palip	erio	lone							
	sses	sment resites (tick	k box le pa pot i	tient has hand injection The patient The patient	appropriate ad an initia has schize has been i	I Special ophrenia cunable to	or other ps adhere to to hospital	sychotic disord	esperidone depot injection or olanzapine depot injection or aripiprazole er ng oral atypical antipsychotic agents espite care, or intensive outpatient or home-based treatment for
		IATION							
				ed after 12 x where ap					
(ith fewer days of intensive intervention than was the case during a psychotic depot injection

I confirm that the above details are correct:

Signed: Date: