

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:

Poliomyelitis vaccine

INITIATION

Re-assessment required after 3 doses

Prerequisites (tick boxes where appropriate)

- For partially vaccinated or previously unvaccinated individuals
- or
- For revaccination following immunosuppression

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

I confirm that the above details are correct:

Signed: Date: