

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:

Diazepam

INITIATION

Prerequisites (tick box where appropriate)

- ☐ Prescribed by, or recommended by a relevant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
- and**
- ☐ Only for use in children where diazepam tablets are not appropriate

I confirm that the above details are correct:

Signed: Date: