## Form RS1398 August 2025

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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	PATIENT:
Name:	Name:
Ward:	NHI:
Poliomyelitis vaccine	
INITIATION Re-assessment required after 3 doses Prerequisites (tick boxes where appropriate)  Or Office For partially vaccinated or previously unvaccinated individuals or Provided in the pro	

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

I confirm that the above details are correct:	
Cianadi	Data