

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:

Adrenaline

INITIATION – anaphylaxis

Prerequisites (tick boxes where appropriate)

- ☐ Patient has experienced a previous anaphylactic reaction which has resulted in presentation to a hospital or emergency department
- or
- ☐ Patient has been assessed to be at significant risk of anaphylaxis by a relevant practitioner

I confirm that the above details are correct:

Signed: Date: