

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: .....

**Measles, mumps and rubella vaccine**

**INITIATION – first dose prior to 12 months**

Re-assessment required after 3 doses

**Prerequisites** (tick boxes where appropriate)

- ☐ For primary vaccination in children  
or  
☐ For revaccination following immunosuppression  
or  
☐ For any individual susceptible to measles, mumps or rubella

**INITIATION – first dose after 12 months**

Re-assessment required after 2 doses

**Prerequisites** (tick boxes where appropriate)

- ☐ For primary vaccination in children  
or  
☐ For revaccination following immunosuppression  
or  
☐ For any individual susceptible to measles, mumps or rubella

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

I confirm that the above details are correct:

Signed: ..... Date: .....