# HOSPITAL MEDICINES LIST
# RESTRICTIONS CHECKLIST



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: .....

## Capsaicin

**INITIATION**

**Prerequisites** (tick box where appropriate)

- ○ For post-herpetic neuralgia or diabetic peripheral neuropathy



I confirm that the above details are correct:

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