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:
Nicotine				
INITIATION Prerequisites (tick boxes where appropriate)				
		0	For perioperative use in patients who have a 'nil by mouth' instruction	
	or	0	For use within mental health inpatient units	
	or	0	Patient would be admitted to a mental health inpatient unit, but is unable to due to COVID-19 self-isolation requirement	
		0	For acute use in agitated patients who are unable to leave the	hospital facilities