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: .....

Poliomyelitis vaccine

INITIATION
Re-assessment required after 3 doses
Prerequisites (tick boxes where appropriate)

- ○ For partially vaccinated or previously unvaccinated individuals

or

- ○ For revaccination following immunosuppression

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

I confirm that the above details are correct:

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