

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: ..... 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: .....