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: .....

Lysine acetylsalicylate

INITIATION

Prerequisites (tick boxes where appropriate)

- ○ For use when an immediate antiplatelet effect is required prior to an urgent interventional neuro-radiology or interventional cardiology procedure

and

- ○ Administration of oral aspirin would delay the procedure

I confirm that the above details are correct:

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