

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: .....

**Nicotine**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

- For perioperative use in patients who have a 'nil by mouth' instruction
- or
- For use within mental health inpatient units
- or
- Patient would be admitted to a mental health inpatient unit, but is unable to due to COVID-19 self-isolation requirement
- or
- For acute use in agitated patients who are unable to leave the hospital facilities

I confirm that the above details are correct:

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