

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:

Paracetamol

INITIATION

Prerequisites (tick box where appropriate)

- ☐ Intravenous paracetamol is only to be used where other routes are unavailable or impractical, or where there is reduced absorption. The need for IV paracetamol must be re-assessed every 24 hours

I confirm that the above details are correct:

Signed: Date: