

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:

Captopril - Oral liq 5 mg per ml

INITIATION

Prerequisites (tick boxes where appropriate)

- ☐ For use in children under 12 years of age
- or
- ☐ For use in tube-fed patients
- or
- ☐ For management of rebound transient hypertension following cardiac surgery

I confirm that the above details are correct:

Signed: Date: