

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:

Methoxyflurane

INITIATION

Prerequisites (tick boxes where appropriate)

- ☐ Patient is undergoing a painful procedure with an expected duration of less than one hour
- and
- ☐ Only to be used under supervision by a medical practitioner or nurse who is trained in the use of methoxyflurane

I confirm that the above details are correct:

Signed: Date: