

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:

Measles, mumps and rubella vaccine

INITIATION – first dose prior to 12 months

Re-assessment required after 3 doses

Prerequisites (tick boxes where appropriate)

- ☐ For primary vaccination in children
- or ☐ For revaccination following immunosuppression
- or ☐ For any individual susceptible to measles, mumps or rubella

INITIATION – first dose after 12 months

Re-assessment required after 2 doses

Prerequisites (tick boxes where appropriate)

- ☐ For primary vaccination in children
- or ☐ For revaccination following immunosuppression
- or ☐ For any individual susceptible to measles, mumps or rubella

Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.

I confirm that the above details are correct:

Signed: Date: