

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:

Rotavirus oral vaccine

INITIATION

Re-assessment required after 2 doses

Prerequisites (tick boxes where appropriate)

- ☐ First dose to be administered in infants aged under 14 weeks of age
and
☐ No vaccination being administered to children aged 24 weeks or over

I confirm that the above details are correct:

Signed: Date: