

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:

Potassium citrate

INITIATION

Prerequisites (tick boxes where appropriate)

- ☐ The patient has recurrent calcium oxalate urolithiasis
and ☐ The patient has had more than two renal calculi in the two years prior to the application

I confirm that the above details are correct:

Signed: Date: