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: .....

Chlorhexidine with cetrimide

INITIATION
Re-assessment required after 3 months
Prerequisites (tick boxes where appropriate)

- ○ Patient has burns that are greater than 30% of total body surface area (BSA)

and

- ○ For use in the perioperative preparation and cleansing of large burn areas requiring debridement/skin grafting

and

- ○ The use of 30 ml ampoules is impractical due to the size of the area to be covered

CONTINUATION
Re-assessment required after 3 months
Prerequisites (tick box where appropriate)

- ○ The treatment remains appropriate for the patient and the patient is benefiting from the treatment

I confirm that the above details are correct:

Signed: ..... Date: .....