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	PATIENT:
Name:	Name:
Ward:	NHI:
Chlorhexidine with cetrimide	
INITIATION Re-assessment required after 3 months Prerequisites (tick boxes where appropriate) O Patient has burns that are greater than 30% of total body surface and O For use in the perioperative preparation and cleansing of large and O The use of 30 ml ampoules is impractical due to the size of the	e burn areas requiring debridement/skin grafting
CONTINUATION Re-assessment required after 3 months Prerequisites (tick box where appropriate) The treatment remains appropriate for the patient and the patient is	henefiting from the treatment
The treatment remains appropriate for the patient and the patient is	benefiting from the treatment

C:	D-1	
Signed.	Date:	
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