HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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 area (BSA) and O For use in the perioperative preparation and cleansing of large burn areas requiring debridement/skin grafting O The use of 30 ml ampoules is impractical due to the size of the area to be covered	
CONTINUATION Be assessment required after 2 months	

essment required after 3 months Prerequisites (tick box where appropriate)

 $m O\,$ The treatment remains appropriate for the patient and the patient is benefiting from the treatment

I confirm that the above details are correct: