

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: .....