

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: .....

**Multivitamin and mineral supplement**

**INITIATION**

Re-assessment required after 3 months

**Prerequisites** (tick boxes where appropriate)

- ☐ Patient was admitted to hospital with burns  
**and**
- ☐ Burn size is greater than 15% of total body surface area (BSA) for all types of burns  
**or**
- ☐ Burn size is greater than 10% of BSA for mid-dermal or deep dermal burns  
**or**
- ☐ Nutritional status prior to admission or dietary intake is poor

I confirm that the above details are correct:

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