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	benefiting from the treatment

C:	D-1	
Signed.	Date:	
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