

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: .....

**Selenium**

**INITIATION – Moderate to severe burns**

Re-assessment required after 3 months

**Prerequisites** (tick boxes where appropriate)

- ☐ Patient has been hospitalised with moderate to severe burns  
**and**  
☐ Treatment is recommended by a National Burns Unit specialist

I confirm that the above details are correct:

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