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

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: .....