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: .....

Copper chloride

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: .....