

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: