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	**PATIENT:**
Name:	Name: ....
Ward:	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

HOSPITAL

I confirm that the above details are correct:

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