

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:

Chlorhexidine with cetrimide

INITIATION

Re-assessment required after 3 months

Prerequisites (tick boxes where appropriate)

- Patient has burns that are greater than 30% of total body surface area (BSA)
- and For use in the perioperative preparation and cleansing of large burn areas requiring debridement/skin grafting
- and The use of 30 ml ampoules is impractical due to the size of the area to be covered

CONTINUATION

Re-assessment required after 3 months

Prerequisites (tick box where appropriate)

- The treatment remains appropriate for the patient and the patient is benefiting from the treatment

I confirm that the above details are correct:

Signed: Date: