

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: