Ref:

**GP Name**

Address 1

Address 2

Address 3

City Postcode

Date

Dear

**Patient name………………………………………………**

This letter is to inform you that the above patient has been commenced on low molecular weight heparin (LMWH) treatment and has been reviewed by the specialist team:

Name of LMWH………………………………………………..Strength (IU/ml)………………………Dose (IU)………………………

Indication ………………………………………………………………………………………………………………….

Proposed treatment duration……………………………………………………………………………………

Date treatment started……………………………………….Treatment stop date………………………………………………

Dose of (IU/mg)…………………………………..next due on the …………………………………………………………………….

Administration information (specialist to tick as appropriate):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient can self-administer |  | Patients relative/existing carer will administer |  | A district nurse referral has been made for administration |  |

As per the Pan Mersey Area Prescribing Committee recommendation, this medicine is categorised as Amber Patient Retained and we would be grateful if you would agree to continue to prescribe this treatment. A copy of the Prescribing Support Information for LMWH can be found here insert link.

***Amber******Patient******Retained*** *requires specialist initiation of prescribing. Prescribing to be continued by specialist until stabilisation of the dose is achieved and the patient had been reviewed by the specialist. Patient remains under the care of specialist (ie not discharged) as occasional specialist input may be required.*

Monitoring to be completed by the GP…………………………………………………………………………

Any additional monitoring to be completed by the specialist …………………………………………………

Results of any additional monitoring will be communicated to the GP with any clinical recommendations.

We will assume that you have agreed to prescribe LMWH to your patient.

If you do not agree to do so, please could you sign and return this letter with your reasons to the haematology department at (insert contact details) within 14 days? Please retain a copy for your records.

Thank you

Yours sincerely

**Name**

Position

**To be completed by GP if prescribing is declined**

I do not agree to prescribe LMWH and sharps bins to the above patient in accordance with Pan Mersey Area Prescribing Support Information for the following reason…………………………………….

GP Signature……………………………………Print………………………………..Date……………………..