HOSPITAL / GP COPY

NHS
Pan Mersey
Area Prescribing Committee

Request by Specialist Clinician to the patient's GP to discharge a patient from secondary care services

Donepezil / Rivastigmine / Galantamine / Memantine

These medicines have been categorised as Amber Initiated by the Pan-Mersey Area Prescribing Committee

Your patient is taking the drug circled or underlined above in accordance with the indication detailed below and has been reviewed to assess the potential long-term efficacy and adverse effects of continued treatment by the specialist team.

Your patient is expected to continue to benefit from treatment for a prolonged period and is considered appropriate for discharge from specialist services.

Attention is drawn to supporting information on the medicines listed above which is enclosed / can be found within the guidelines section of the Pan-Mersey APC website http://www.panmerseyapc.nhs.uk/

Part 1: To be completed by the Consultant /Associate Specialist /Specialist Registrar or Specialist Nurse (who must be a prescriber)

Date:

Name of patient:

Address:

DOB:

NHS No:

Patient Hospital number:

Alternatively add addressograph here

Diagnosed condition/indication:

Main Carer / Guardian: _____

Contact Number: _____

Please also add addressograph here

Dear Dr……

I request your agreement to discharge this patient, for whom you already prescribe their dementia drug treatment, as allowed within the drug's Pan-Mersey Amber Initiated status.

Drug: …… **Dose: ……**

Current treatment has been maintained for [ ] months and continues to demonstrate a favourable response.

The duration of treatment benefit will vary significantly between individuals. Advice on when to stop the drug and when to seek specialist advice/review is contained within the supporting information;

However, earlier re-referral may be suitable:

- Should concerns arise or if there are doubts about continued benefits.
- If cardiac conditions, upper GI ulceration and/or seizures develop as cholinesterase inhibitors (donepezil, rivastigmine and galantamine) can cause/aggravate these conditions.

Referrals are assessed to determine response time but in appropriate cases assessments can take place on the same day.

Blood Monitoring

There are no requirements for on-going blood tests

Details of Specialist Clinician

Name _____Date_____

Consultant / Prescribing member of Specialist Team

Signature _____

When signed by a prescriber who is not the Consultant, it is the Supervising Consultant who takes medico legal responsibility for this agreement.

Consultant: _____

Contact details*:*

Telephone number: _____ Ext:_____

Address for return of documentation _____

_____

_____

Part 2: To be completed by the Primary Care Clinician

Please also add addressograph here

*I agree to accept discharge of [name of patient] from secondary care dementia services. ☐

*I do not agree to accept the requested discharge of [name of patient] from secondary as Part 1 of the request is incomplete.
I will reconsider on completion. ☐

*I do not agree to accept the requested discharge of [name of patient] from secondary care dementia services for the following clinical reason: ☐

_____

GP _____Date _____

*please tick the appropriate box and enter the patient's name

GP: *Please sign and return copy* ***within 21 days*** *to:*

…….. Dept. [Insert contact details]

……..

Please retain original copy for your clinical records. Thank you