HOSPITAL / GP COPY

Request by Specialist Clinician to the patient's GP to take over the prescribing from secondary care services

NHS
Pan Mersey
Area Prescribing Committee

Donepezil / Rivastigmine / Galantamine / Memantine
These medicines have been categorised as Amber Initiated by the Pan-Mersey Area Prescribing Committee

Your patient has been identified as being suitable to receive the drug circled or underlined above in accordance with the indication detailed below. They have been started on treatment and reviewed to assess the efficacy and adverse effects of their treatment by the specialist team.

This medicine has been considered as appropriate for prescribing in primary care. Your patient's dose is now stable and is detailed in the attached clinic letter.
Supporting information on the medicines listed above 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:

Diagnosed condition/indication:

Main Carer / Guardian: _____

Contact Number: _____

Alternatively add addressograph here

Please also add addressograph here

Dear Dr……

I request that you undertake the continued prescribing of this patient's dementia drug treatment in recognition of its Pan-Mersey Amber Initiated status.

Drug: …… **Dose: ……**

Last Prescription Issued: ….. / ….. / ….. Next Supply Due: ….. / ….. / …..

I confirm that the patient has been stabilised and reviewed on the above regime and demonstrates a favourable benefit/adverse effect ratio such that treatment is not expected to change.

I confirm that the patient and/or carer has been informed that drug treatment will cease when the benefits of treatment are no longer present.

Licensed Use: **YES / NO** (specialist please delete as appropriate)
If unlicensed or off-label I confirm, informed consent has been received and is documented in the clinical record.

Regular [specify] monthly reviews by Specialist clinician to continue.

Patient's next review date: ……. / ……. / …….

Other relevant medical and psychiatric conditions and any areas of concern for this patient are highlighted in the accompanying clinic letter.

Details of Specialist Clinician

Name _____Date_____

Consultant / Associate Specialist / Specialist Registrar / Specialist Nurse ****circle or underline as appropriate***

Signature _____

In the case of Specialist Nurses please also provide the name of 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 prescribe (add drug name) for the above patient ☐

*I do not agree to prescribe (add drug name) for the above patient ☐
as Part 1 of the request is incomplete. I will reconsider on completion.

*I do not agree to prescribe (add drug name) for the above patient ☐
for the following clinical reason (please provide any supporting information as appropriate):

_____ _____.

_____ _____.

*please tick as appropriate

Even if I do not agree, I will record that the patient is prescribed (add drug name) to allow prescribing software to identify any current/future drug interactions of note, and inform the prescriber of any test results or co-morbidity that are relevant.

GP _____Date _____

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

…….. Dept. [Insert contact details]

……..

Please retain original copy for your clinical records. Thank you