**THE WALTON PAIN CLINIC**

Lower Lane

Fazakerley

Liverpool

Tel: 0151 529 5749

Fax: 0151 529 5486

**Dr**

**Consultant in Pain Medicine**

Ref:

Clinic Date:

Date dictate:

Date Typed:

**GP Name**Address line 1
Address line 2
Address line 3
City Postcode

Date

Dear Dr

**Patient name: DOB:**

**NHS number:**

This letter is to inform you that the above patient has been stabilised on **oral methadone tablets** for pain management. A full, individualised plan has been agreed with the patient and is included with this letter.

|  |  |
| --- | --- |
| Their dose has been stabilised at methadone |  |

As per Pan Mersey Area Prescribing Committee recommendation, this medicine is categorised as Amber retained. We keep the patients on annual follow-up and will be involved in any dose change decision. We would be grateful if you would agree to continue to prescribe methadone tablets. A copy of the Prescribing Policy Statement and Prescribing Support Information for methadone tablets can be found here: <https://www.panmerseyapc.nhs.uk/media/2094/methadone.pdf>

Any changes in the dose will be conducted by the pain clinic and this will be communicated to you in writing.

|  |  |
| --- | --- |
| The patient will require a new prescription on |  |

|  |  |
| --- | --- |
| The patient will be seen in clinic on |  |

The following opioid medicines have stopped prior to stabilisation of methadone:

|  |
| --- |
| (Nil or list as appropriate) |

Their other medicines to continue are:

|  |
| --- |
| (Nil or list as appropriate) |

A baseline ECG was performed and the patient’s QTc interval was noted to be normal.

|  |
| --- |
| (Any additional free text/blank ) |

To acknowledge whether you agree to prescribe oral methadone tablets for your patient, please could you sign and fax this letter back to the pain clinic secretary on 0151 529 5486 within the next 14 days? Please retain a copy for your records.

If you would like to discuss the care of this patient further, I am happy to do so. Please contact the pain clinic secretary on the number above, who will forward your details to me.

Yours sincerely

**Dr
Consultant in Pain Medicine**

**To be completed by GP**

I agree / do not agree\* to prescribe methadone tablets to the above patient in accordance with Pan Mersey Prescribing Committee policy and prescribing Support Information.

(\*delete as appropriate)

|  |  |
| --- | --- |
| GP signature |  |

|  |  |
| --- | --- |
| Print name |  |

|  |  |
| --- | --- |
| Date |  |