NHS
Pan Mersey
Area Prescribing Committee

HOSPITAL / GP COPY

Request by Specialist Clinician to the patient's GP to Prescribe

Atypical Antipsychotics - oral

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

The Pan Mersey Area Prescribing Committee considers atypical antipsychotics as being suitable for primary care prescribing once treatment has been successfully established.

Your patient is taking an oral atypical antipsychotic medicine in accordance with the indication detailed below. Whilst on this medicine your patient has been assessed by the specialist team to ensure it is effective, is satisfactorily tolerated and your patient is compliant with treatment.

Your patient's current dose is detailed in the attached clinic letter.

Supporting information on the medicine group 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 / prescribing member of Specialist Team

Date:

Name of patient:

Address:

DOB:

NHS No:

Please add addressograph here

Patient Hospital number:

Diagnosed condition/indication:

Main Carer / Guardian: _____

Contact Number: _____

Dear Dr……

I would be grateful if you would undertake the continued prescribing of this patient's oral atypical antipsychotic drug treatment in recognition of its Pan-Mersey Amber Initiated status.

Drug: …… **Dose: ……**

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

I confirm that your patient's condition is stable and that the medication is effective and demonstrates a favourable benefit/adverse effect ratio.

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.

I confirm that your patient remains under review by the specialist team who will carry out monitoring relating to condition and treatment.

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 / prescribing member of Specialist Team
circle or underline as appropriate

Signature: _____

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

Consultant: _____

Contact details

Address for return of documentation _____

_____

_____

Telephone number: _____ **Ext:** _____

Fax number: _____

E-mail address: _____

Please also add addressograph here

Part 2: To be completed by the Primary Care Clinician

*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. ☐

*Before agreeing to prescribe (add drug name) for the above patient I require the following information and/or assurances. ☐

_____ _____.

_____ _____.

*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 consultant/community team of any relevant test results or co-morbidities.

GP signature: _____ **Date:** _____

GP name: _____

Please sign and send copy of Part 1 and Part 2 ***within 14 days*** *to return address stated in Part 1:*

Please retain original copy for your clinical records. Thank you

Please also add addressograph here