HOSPITAL / GP COPY

Request by Specialist Clinician to discharge a patient from secondary care services

Atypical Antipsychotics - oral

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

Your patient is taking an oral atypical antipsychotic drug 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 has responded well to antipsychotic treatment, remains well and I am assured regarding current and future compliance. He/she is expected to continue to benefit on this treatment and is therefore considered appropriate for discharge in accordance with the drug's Pan- Mersey Amber Initiated status.

Attention is drawn to supporting information on the medicine group listed above which is enclosed / can be found within the guidelines section of the
Pan-Mersey APC 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:
Patient Hospital number:

Please add addressograph here

Diagnosed condition/indication:

Main Carer / Guardian: ______________________________

Contact Number: ______________________________

Dear Dr……………………………

I would be grateful for your agreement to allow the specialist team to discharge this patient to your care as allowed within the drug's Pan-Mersey Amber Initiated status.
You already prescribe this patient's oral atypical antipsychotic drug treatment which is detailed below.

Drug: …………………… **Dose: ……………………**

Current treatment has been maintained for [ ] months and continues to be well tolerated and demonstrate a favourable response. Compliance is established to the satisfaction of the specialist team and relapse is not expected.

Information to support primary care prescribing of the stated medicine and discharge from specialist services information is enclosed / can be found within the guidelines section of the Pan-Mersey APC website http://www.panmerseyapc.nhs.uk/

Advice on when to seek specialist advice/review is contained within the supporting information; however, you are encouraged to contact the team for advice without re-referral using the contact details below; also

Re-referral would be suitable if:

- There is a deterioration/concern regarding your patient's mental health
- Your patient is expressing a wish to stop the atypical antipsychotic medication for a psychotic illness
- There are concerns regarding treatment compliance
- Your patient's cardiac health changes - appropriateness of prescription will need to be discussed and consideration given for referral to cardiology.
- There are any concerning abnormal physical or laboratory results that may relate to atypical antipsychotic drug treatment
- Any other concerning physical health problems arise
- Concerns arise regarding tolerability consequent to the emergence of medical co-morbidities, potential drug interactions and alcohol and drug misuse

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

Monitoring to date

By signing this letter I am confirming that monitoring is up to date in accordance with NICE guidelines and the drug's data sheet and any concerns have been previously communicated or are highlighted in the accompanying clinic letter.

Future monitoring required in primary care post discharge
Annual physical health checks and provision of lifestyle advice are required:
BP, pulse, weight, CVD assessment (including an ECG).

Annual blood testing is required:
FBC, U+E's, LFT's, TFTs (bipolar only), lipids, HbA1c or fasting BM's (6 monthly olanzapine).
Prolactin is only required if there are symptoms of hyperprolactinaemia.

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 ____

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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 accept discharge of [name of patient] from secondary care mental health services. ☐

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

*Before agreeing to accept discharge of [name of patient]) I require the following information and/or assurances. ☐

________________________________ ________________________________.

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

________________________________ ________________________________.

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

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