Claypath & University Medical Group

26 Gilesgate

Durham

DH1 1QW

Tel: 0191 3746888

Re: Full Name D.O.B Date of Birth NHS Number: NHS Number ,

13-Sep-2023

Request for further details before accepting shared care agreement

Dear Specialist,

In response to your request for a shared care agreement for the above patient, we require that you complete the below form to confirm all NICE required checks have been performed so we can be assured an ongoing prescription is safe.

The shared care agreement and the information provided by the specialist must meet all of the below criteria.

If a criterion is not met, we will be unable to accept shared care.

Regards,

Medication details

Medication name	
Dose	
Indication	
Monitoring requirements for the GP practice	

Pre-treatment specialist responsibilities

Has evidence of a **full mental health and social assessment**, including risk assessment for substance misuse and drug diversion been provided?	Yes ☐	No ☐
Has evidence of a **full cardiovascular assessment (performed by the specialist team)** been provided?	Yes ☐	No ☐
Did the cardiovascular exam include **heart auscultation**?	Yes ☐	No ☐
Date exam performed and details of what was done (must be completed):		

Initiation of medication

Has the **specialist prescribed the drug** during initiation and dose titration and **has the patient been stable on the current dose for at least 3 months**?	Yes ☐	No ☐
Has the patient had a **3-month review with the specialist** after starting the medication?	Yes ☐	No ☐
Has a **shared care agreement with clear dosing and contact information** been provided?	Yes ☐	No ☐
Has a **recent blood pressure, pulse rate and BMI** been provided (taken after being stabilised on medication)?	Yes ☐	No ☐
Height: Weight: Pulse: BP: Date:		

Ongoing Review

Has the **patient been advised they must attend the surgery for 6-monthly BP/Pulse/Weight checks**?	Yes ☐	No ☐
Has the specialist agreed to **provide an annual review**?	Yes ☐	No ☐

For ADHD Requests Only:

Are the following attributes present in the diagnostic letter – please provide more information if not clearly stated in the letter.		
Consideration of a differential diagnosis or other possible diagnoses	Yes ☐	No ☐
Use of validated diagnostic scoring	Yes ☐	No ☐
Consideration of contextual history For example, interviews with relatives or teachers, reviews of school reports	Yes ☐	No ☐
A treatment plan that considers psychological as well as medical therapy	Yes ☐	No ☐

Psychiatrist details

We agree to provide ongoing support to the GP practice if issues emerge while the patient takes the medication	Yes ☐	No ☐
Named psychiatrist responsible for initiating medication and providing ongoing support		
Email address of specialist:		
GMC Number: If the recommendation comes from a clinician who is not a doctor, please provide the name and GMC number of the supervising doctor. If there is no supervising doctor, please highlight and explain governance processes in separate letter.		
Is the clinic CQC registered?	Yes ☐	No ☐
If no, please confirm the specialist holds also works for a provider who is CQC registered. Please specify which provider.		