**Request to continue prescribing of XXXX in primary care**

**Information for the GP Practice**

|  |  |  |
| --- | --- | --- |
| **XXXX (add therapeutic area) specialist** | **GP Details** | **Patient details** |
| Name: | Name: | Surname: |
| Site/clinic initiating: | Address: | Forename: DOB: |
| Tel: | Tel: | Address: |
| Fax: | Fax: | Postcode: |
| Nhs.net email | Nhs.net email: | NHS no: |

**Dear Dr** …………………..

Your patient has been started on XXXX for the management of XXXX.

The patient has completed X months of treatment under Specialist care and as per South East London Area Prescribing Committee (SEL APC) recommendations we now request you to take over prescribing and management of this medicine.

**I confirm that the patient: - add any caveats stipulated by the APC**

|  |  |  |
| --- | --- | --- |
| 1. | E.g: Has been initiated on XXXX in line with SEL APC recommendations for this drug | 🞏 YES (tick box) |
| 2. | E.g: Has tolerated the treatment well and there are no concerns about adverse effects  | 🞏 YES (tick box) |
| 3. | etc | 🞏 YES (tick box) |

**Note: The specialist completing this form MUST answer the X questions above before sending this request to the practice**

**Further information: add any patient monitoring parameters**

|  |  |  |
| --- | --- | --- |
| **Patient parameters** | **Date of test** | **Result** |
| E.g. HbA1C prior to treatment |  |  |
| E.g. HbA1C after 6 months treatment |  |  |
|  |  |  |
|  |  |  |

**Recommended on-going monitoring by the practice**: **add what needs to be monitored and intervals**

* E.g HbA1c and renal function at least every 12 months or in line with their individualised diabetes care plan

Please contact the specialist **XXXX** team via the contact details above if you have any questions about the treatment of this patient or the information contained in this letter.

Yours sincerely

**Print Name:**

**References**

**GP PRACTICE RESPONSE: to be completed and signed by the GP if NOT willing to take on prescribing**

**responsibility and returned to the XXXX specialist:**

This is to confirm that I am not willing to accept prescribing responsibility for XXXX for this patient for the following reason:

…………………………………………………………………………………………………………………………..

**GP name: ………………………………GP signature: ………………………………………………Date: ……/….…/…....**