**RIVAROXABAN for the prevention of atherothrombotic events after an Acute Coronary Syndrome (unstable angina, non-ST segment elevation myocardial infarction (NSTEMI) or ST segment elevation myocardial infarction (STEMI))**

## Transfer of Prescribing Responsibility

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| --- | --- |
| **Patient Details:**  **Name:....................................................….......... DOB: ……/………/…………**  **Hospital Number: ……………………………… Address:……………………………………………………….**  **NHS Number: ……………………………………….. …………………………………………………………………………..** | |
| **GP Practice Details:**  Name: ………………………………………  Address: ……………………………………  Tel no: ………………………………………  Fax no: ………………………………………  NHS.net e-mail: …………………………… | **Consultant Details:**  Consultant Name:.............................................................  Organisation Name:...........................................................  Clinic Name:…………………………………………………..  Address: ………………………………………………………  Tel no: …................................................…………………..  Fax no:: …………………… NHS.net email:: ………………………… |
| Dear Dr………….  This patient has been initiated on rivaroxaban in accordance withSouth London guideline for the prevention of atherothrombotic events after an ACS.  I have now supplied the first three months of therapy for this patient and am writing to transfer the prescribing responsibility for this patient’s on-going treatment from ….. /…../……  This transfer of care document should be reviewed in conjunction with the rivaroxaban screening checklist and notification sent previously by the initiating clinician. If this has not been received contact the consultant named above for details.  ***Details of treatment plan on transfer*** (Tick appropriate box and complete relevant information)   |  | | --- | | ***Rivaroxaban 2.5mg twice daily to continue in combination with:***   * **Aspirin 75mg daily plus clopidogrel 75mg daily OR** * **Aspirin 75mg daily alone**   **Antiplatelet(s) duration plan:** | | **Duration of rivaroxaban:**   * **12 month only and to stop on …../…../…..** * **……months and to stop on …../…../…..** | | **Next Hospital follow up appointment on**: |   Any other relevant information: ……………………………………………………………………………………………………………  …………………………………………………………………………………………………………………………………………………  …………………………………………………………………………………………………………………………………………………  **Monitoring:**   |  |  |  |  | | --- | --- | --- | --- | | **Test** | **Result** | **Date of test** | **Please repeat test in:** | | Serum Creatinine |  |  | ………….………..months | | Creatinine clearance (CrCl\*) |  | | Haemoglobin |  |  | ………….………..months | | ALT or AST (delete as appropriate) |  |  | ………….………..months |   \*eGFR should NOT be used to guide dosing decisions. Creatinine clearance must be estimated using the [Cockcroft-Gault equation calculator](http://www.mdcalc.com/creatinine-clearance-cockcroft-gault-equation/#from-the-creator) or refer to the South London creatinine clearance information sheet   |  | | --- | | * I confirm that I have prescribed in accordance with the local ACS guidelines * I confirm that the patient has been made aware of the benefits and risks of rivaroxaban therapy, including   Risks of both major and minor bleeding, and that they know how to seek medical help should bleeding occur   * I confirm that I have provided an anticoagulation card and/or medic-alert bracelet at initiation * I confirm the patient has consented to treatment * For female patients of child-bearing age: I have explained the risks of falling pregnant whilst on this treatment   and recommended appropriate contraceptive measures are taken    **Signed:……………………………………. Name of Clinician:…………………………… Date: …………….** | | |

In the event that there are any concerns regarding the acceptance of the prescribing responsibility for this medication please contact the consultant named above for details: \*\*\*To be completed by individual organisations xxxxxxx\*\*\*