**IVABRADINE for the treatment of Postural Orthostatic Tachycardia**

**Syndrome (POTS) or Inappropriate Sinus Tachycardia (IST)**

**Transfer of Prescribing Responsibility**

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| **Section A: To be completed by the initiating organisation / clinician INITATING ORGANISATIONS TO ADD LOCAL CONTACT DETAILS FOR SPECIALIST SERVICE (TEL / EMAIL) FOR QUERIES** | |
| **Patient Details:**  **Name:........................................ DOB: …./.…/.… Hospital Number: ……………………… NHS No: ……………………….** | |
| **GP Practice Details:**  Name: ………………………………………  Address: ……………………………………  Tel no: ………………………………………  NHS.net e-mail: …………………………… | **Consultant Details:**  Consultant Name:.......................................................  Organisation Name:...........................................................  Clinic Name:……………………………………………  Address: ……………………………………………  Tel no: …...................... NHS.net email: ………………………… |
| Dear Dr…………  **This patient is on a ivabradine for:** Postural Orthostatic Tachycardia Syndrome (POTS) / Inappropriate Sinus Tachycardia (IST) (delete as appropriate)  **I have supplied the first three months of therapy for this patient and the dose of ivabradine is now stable. I am requesting your agreement to transfer the prescribing responsibility for this patient’s on-going treatment from …/…/… in accordance with the South East London Area Prescribing Committee (SEL APC) formulary recommendations.**  I will review the patient at least annually throughout treatment. The following investigations have been performed and are acceptable for transfer of care.   |  |  |  |  | | --- | --- | --- | --- | | **Test** | **Result** | **Date of test** | **Please repeat test in:** | | Blood Pressure |  |  | Months | | Heart Rate |  |  | Months | | Serum Creatinine |  |  | Months | | Creatinine Clearance\* |  | | Aspartate Transaminase (AST) or Alanine Transaminase (ALT) |  |  | Months |   \*Estimate creatinine clearance (CrCl) using the Cockcroft-Gault equation  **Contact details of specialist nurse for GPs to access:**  Name: ………………………….. Tel no:……………………………. NHS.net email: …………………………  **Other relevant information**: ………………………………………………………………………………………………………………..  …………………………………………………………………………………………………………………………………………………..   |  | | --- | | * I confirm that I have prescribed in accordance with the SEL APC guidelines * I confirm the patient has consented to treatment * I confirm that the patient has been made aware of the benefits and risks of ivabradine therapy; including risk   of bradycardia and visual symptoms and that they know how to seek medical help should symptoms occur   * I confirm patient has access to specialist nursing support (including contact numbers)   **Signed:……………………………………. Name of Clinician:…………………………… Date: …………….** | | |
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| **Section B: To be completed and signed by the GP if NOT willing to take on prescribing responsibility and returned to the specialist clinician as detailed in Section A above.** |
| This is to confirm that I am not willing to accept the transfer of care of prescribing ivabradine for this patient ***for the following reason***:  ……………………………………………………………………………………………………………….  **GP name: ………………………………GP signature: ………………………………………………Date: ……/….…/…....**  ***(This transfer of care document should be reviewed in-conjunction with the drug screening checklist sent previously by the initiating clinician - if not received contact consultant named above for details)*** |