**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.

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| **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**: ………………………………………………………………………………………………………………..…………………………………………………………………………………………………………………………………………………..

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| * 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)*** |