

**Shared Care Agreement form**

**Disease modifying drugs (DMARDs)**

**Request by Specialist Clinician for the patient’s GP to enter into a shared care agreement**

**Part 1** - **To be signed by Consultant / Associate Specialist / Speciality Trainee or Specialist Nurse (who must be a prescriber)**

|  |  |
| --- | --- |
| **Dear Doctor:** | Click or tap here to enter text. |
| **Name of Patient:** | Click or tap here to enter text. |
| **Address:** | Click or tap here to enter text. |
|  | Click or tap here to enter text. |
|  | Click or tap here to enter text. |
| **Date:** | Click or tap to enter a date. |
| **Patient NHS Number:** | Click or tap here to enter text. |
| **Patient Hospital Number:** | Click or tap here to enter text. |
| **Diagnosed Condition:** | Click or tap here to enter text. |

**I request that you prescribe:**

|  |  |
| --- | --- |
| (1)  | Click or tap here to enter text. |
| (2) | Click or tap here to enter text. |
| (3) | Click or tap here to enter text. |
| (4) | Click or tap here to enter text. |

for the above patient in accordance with the LMMG shared care guideline(s) (Available on the LMMG website).

|  |  |
| --- | --- |
| **Last Prescription Issued:**  | Click or tap to enter a date. |
| **Next Supply Due:**  | Click or tap to enter a date. |
| **Date of last blood test:** | Click or tap to enter a date. |
| **Date of next blood test:**  | Click or tap to enter a date. |
| **Frequency of blood test:**  | Click or tap here to enter text. |

I confirm that the patient has been stabilised and reviewed on the above regime in accordance with the Shared Care guideline.

If this is a Shared Care Agreement for a drug indication which is unlicensed or off label, I confirm that informed consent has been received from the patient.

I will accept referral for reassessment at your request. The medical staff of the department are available if required to give you advice.

**Details of Specialist Clinicians**

|  |  |
| --- | --- |
| **Name:** | Click or tap here to enter text. |
| **Date:** | Click or tap to enter a date. |
| **Position:**  | Choose an item. |
| **Signature:**  | Click or tap here to enter text. |

(An email from the specialist clinician will be taken as the authorised signature)

In all cases, please also provide the name and contact details of the Consultant.

When the request for shared care is made by a Specialist Nurse, it is the supervising consultant who takes medicolegal responsibility for the agreement.

|  |  |
| --- | --- |
| **Consultant** | Click or tap here to enter text. |
|  |
| **Contact Details** |
| **Telephone Number** | Click or tap here to enter text. |
| **Extension** | Click or tap here to enter text. |
| **Email Address** | Click or tap here to enter text. |

**Part 2** - **To be completed by Primary Care Clinician (GP)**

I agree to prescribe and monitor Click or tap here to enter text. for the above patient in accordance with the LMMG shared care guideline(s) commencing from the date of next supply / monitoring (as stated in Part 1 of the agreement form).

|  |  |
| --- | --- |
| **Name:** | Click or tap here to enter text. |
| **Date:** | Click or tap to enter a date. |
| **Signature:**  | Click or tap here to enter text. |

*Please sign and return a copy* ***within 14 calendar days*** *to the address above* **OR**

If you **do not** agree to prescribe, please sign below and provide any supporting information as appropriate:

I **DO NOT** agree to enter in to a shared care agreement on this occasion.

|  |  |
| --- | --- |
| **Name:** | Click or tap here to enter text. |
| **Date:** | Click or tap to enter a date. |
| **Signature:**  | Click or tap here to enter text. |
| **Further information:** | Click or tap here to enter text. |

**Please provide the patient with a copy of the shared care agreement form.**