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 / Specialist registrar or Specialist Nurse

Dear Dr: _____

Name of patient: _____

Address: _____

_____

Date: _____

Patient NHS No: _____

Patient hospital unit No: _____

Diagnosed condition: _____

If using addressograph label please attach one to each copy

I request that you prescribe:

(1) _____
(2) _____
(3) _____
(4) _____

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

Last Prescription Issued: _____ **Next Supply Due:** _____

Date of last blood test: _____ **Date of next blood test:** _____

Frequency of blood test: _____ **Treatment duration:** _____

Any additional drug monitoring information:

_____

_____

_____

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: _____ **Date:** _____

Consultant / Associate Specialist / Specialist Registrar / Specialist Nurse/Specialist Pharmacist.
circle or underline as appropriate

Signature: _____
(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: _____

Contact details

Telephone number: _____ **Ext:** _____

Email address:

_____

_____

_____

Part 2 - To be completed by Primary Care Clinician

I agree to prescribe and monitor _____ 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).

GP signature: _____ **Date:** _____

GP name (Please print): _____

GP: *Please sign and return a copy* ***within 14 calendar days*** *to the address above.*

OR

GP: If you do not agree to prescribe, please delete the section above and provide any supporting information as appropriate below:

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