# Appendix 2: Shared Care Request letter (Specialist to Primary Care Prescriber)

Dear *[insert Primary Care Prescriber's name]*

Patient name: *[insert patient's name]*

Date of birth: *[insert date of birth]*

NHS Number*: [insert NHS Number]*

Diagnosis: *[insert diagnosis]*

As per the agreed *[insert APC name]*shared care protocol for *[insert medicine name]* for the treatment of *[insert indication],* this patient is now suitable for prescribing to move to primary care.

The patient fulfils criteria for shared care and I am therefore requesting your agreement to participate in shared care. Where baseline investigations are set out in the shared care protocol, I have carried these out.

I can confirm that the following has happened with regard to this treatment:

|  |  |
| --- | --- |
|  | **Specialist to complete** |
| *The patient has been initiated on this therapy and has been on an optimised dose for the following period of time:* |  |
| *Baseline investigation and monitoring as set out in the shared care documents have been completed and were satisfactory* | *Yes / No* |
| *The condition being treated has a predictable course of progression and the patient can be suitably maintained by primary care* | *Yes / No* |
| *The risks and benefits of treatment have been explained to the patient* | *Yes / No* |
| *The roles of the specialist/specialist team/* *Primary Care Prescriber / Patient and pharmacist have been explained and agreed* | *Yes / No* |
| *The patient has agreed to this shared care arrangement, understands the need for ongoing monitoring, and has agreed to attend all necessary appointments* | *Yes / No* |
| *I have enclosed a copy of the shared care protocol which covers this treatment/the SCP can be found here (insert electronic/ web link)* | *Yes / No* |
| *I have included with the letter copies of the information the patient has received* | *Yes / No* |
| *I have provided the patient with sufficient medication to last until* |  |
| *I have arranged a follow up with this patient in the following timescale* |  |

Treatment was started on *[insert date started]* and the current dose is *[insert dose and frequency]*.

If you are in agreement, please undertake monitoring and treatment from *[insert date]* NB: date must be at least 1 month from initiation of treatment.

The next blood monitoring is due on *[insert date]* and should be continued in line with the shared care guideline.

Please could you reply to this request for shared care and initiation of the suggested medication to either accept or decline within 14 days.