

This form is a request for the General Practitioner to take over the prescribing of long-acting injectable antipsychotics (LAIs). CMHT will continue to administer under shared care arrangement			
GP Name & Address			
Patient's Name		Date of birth	
NHS number			
Name of medicine		Dose	
Frequency of administration			
Route		Gluteal / Deltoid (delete as applicable)	
Diagnosis and Rationale for Treatment (including brief details of other agents tried and where applicable, adverse effects and any ongoing monitoring requirements)			
CMHT will retain responsibility of monitoring mental health and will agree to send written confirmation to GP when LAIs are administered.			
Name of Care-co-ordinator if applicable: _____			
Investigations done at baseline	Date Checked	Comments	Continued monitoring by GP
Weight (include BMI ideally)			Three monthly
Fasting lipids			Annual
Blood glucose (random/ fasting)			Annual
Liver Function			Annual
ECG			Annual (if indicated)
U&Es			Annual
FBC			Annual
Prolactin			Annual
Blood pressure and pulse			Annual
We accept shared care responsibilities			
Consultant Psychiatrist Name			
Signature			
Date			
Contact number			
E-mail Address			
GP Signature			

This form should be signed by the GP and kept in the practice notes. A copy should also be sent to the Consultant Psychiatrist for scanning and entry to the patients' electronic notes, Open RIO.