

**This form is a request for the General Practitioner to take over the prescribing & administration of long-acting injectable antipsychotics (LAIs) under shared care arrangement**

GP Name & Address

<b>Patient's Name</b>		<b>Date of birth</b>	
<b>NHS number</b>			
<b>Name of medicine</b>		<b>Dose</b>	
<b>Frequency of administration</b>		<b>Last dose given</b>	
<b>Route</b>	Gluteal / Deltoid	<b>Side of last dose</b>	Right / Left

**Diagnosis and Rationale for Treatment** (including brief details of other agents tried and where applicable, adverse effects and any ongoing monitoring requirements)

**Please contact CMHT duty staff on \_\_\_\_\_ if the patient misses TWO successive appointments**

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**

<b>Consultant Psychiatrist Name</b>	
<b>Signature</b>	
<b>Date</b>	
<b>Contact number</b>	
<b>E-mail Address</b>	
<b>GP Name</b>	
<b>GP Signature</b>	

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.