

**GP FEEDBACK/DECISION ON**

**PRESCRIPTION RECOMMENDATION FROM SPECIALIST CARE**

We would remind all clinicians involved in the care of the patient to ensure timely communication in order to ensure patient care is not affected through delays/interruption to treatment.

**Dr**. *Insert name here*

*Full surgery address*

*Surgery contact number*

Dear Dr …………………………………………………………………………

Specialty ……………………………………………………………………….

Hospital …………………………………………………………………………

Please see attached copy of your recent letter / discharge summary. *(Attach copy to this letter)* for the following patient: *...................................................................*

We as a Practice have reviewed your request to prescribe the following drug:

…………………………………………………………………………………..

in the following indication: ..........................................................................

We regret to inform you that we will be **unable** to take over prescribing responsibility for this drug for the following reason(s): ***(please highlight)***

1. Unlicensed drug or indication outside the SBUHB approved formulary list.
2. Insufficient experience and expertise in dealing with this drug.
3. Hospital-only drug on SBU Health Board formulary guidance
4. Insufficient information given or pre-prescribing checks completed for Primary Care to take over prescribing ***(please specify):***

…………………………………………………………………………………………..

…………………………………………………………………………………………..

1. Inadequate resources to provide the monitoring required for this drug ***(please specify):***

...........................................................................................................................................

1. Other ***(please specify):***

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

We would therefore ask that if you feel this patient requires this drug that you continue to supply the patient yourself directly until such issues are addressed.

**Please ensure the practice and the patient are advised of the management plan and / or prescribing route for this medication so that our records can be updated accordingly.**

**Dr.** *Insert signature here* **Date:**

**Direct telephone / email for GP:**