**Request for New Shared Care Agreement for patients transferred to new GP Practice**

**GP Practice**

* Please complete this form for patients taking a shared care drug who have recently registered with a new GP
* This form should be completed by the new GP and sent to the specialist (or specialist team) who signed the original shared care request form in order to request a new signed shared care agreement form

**Specialist**

* The specialist should complete the shared care agreement form attached to the relevant shared care guideline and return to the GP

**From (GP):**  \_\_\_\_\_\_ \_\_\_ **Telephone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New GP Practice name and address (or Practice stamp):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To (Specialist):**  \_\_\_

Patient details

Name: ID Number:

Address: DOB:

Diagnosed condition:

Previous GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shared care drug details

Drug name: Dose:

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The patient should be reviewed by the GP by: