**ADHD Patient Acceptance Agreement.**

This agreement has been created to formalise the terms by which CARTERKNOWLE AND DORE MEDICAL PRACTICE can accept and maintain a SHARED CARE AGREEMENT to allow NHS prescription of medications used for **ADHD**.

The reason we have created a separate (*and additional*) agreement is that Shared Care Agreements vary by provider, some are from NHS, some are from the private sector, which can make it very difficult to adopt a unified approach. In addition, patients come to a diagnosis either through fully self-funding a private assessment, a hybrid via Right to Choose, or via a NHS pathway, and NHS services are severely stretched.

The agreement below must be signed by the patient (*or a parent/responsible party if below the age of 16*) prior to the practice accepting any shared care agreement. If this agreement is not signed or the terms are broken, then the practice will withdraw from Shared Care and any associated prescribing will end.

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| **Once a shared care agreement is accepted** | |
| **What a GP can do:** | **What a GP cannot do:** |
| * Set up monitoring with the practice. * Prescribe medications | * GP cannot change dose or switch to non- equivalent medications. * GP cannot start new ADHD medications. |

**Agreement, by signing this agreement I (or the patient) enter (into) an understanding with the practice surrounding the terms of accepting Shared Care for ADHD type medications.**

* **I accept that if my diagnosis is made outside of local NHS organisations, it may not be accepted by local NHS organisations and may need reassessment.**
* **I agree to follow the terms of the Shared Care Agreement** (*this is the Sheffield one and we advise all organisations to follow this, means everyone follows one agreement rather than the practice holding multiple shared care agreements with slight differences between*).
* I acknowledge that a Shared Care Agreement requires a specialist provider for the GP to “share” the care with, if there is no specialist then shared care cannot take place. If the specialist provider does not respond to queries or problems in a timely fashion, then the GP may also end this agreement and Shared Care Prescribing.
* I will only sign this when I (*or the patient*) am (*are*) on a stable dose of medications.
* **I will comply with the monitoring requirements**:  
  Adult: Annual review with the GP (*either in person, by phone or electronic*) and 6 monthly checks of blood pressure, pulse, height and weight. Adults who are stable do not ordinarily need an annual specialist review. However, if the practice deems the case complex, we can also require a patient to have annual specialist reviews to meet this agreement.   
  Children (under 16 years old): All the above AND they must have an annual review with the specialist service.
* **If my GP deems that I am not compliant with my monitoring or terms of my prescribed dose, the GP can stop prescribing medication and I will need to contact my specialist for further prescriptions. I accept there is no obligation for the GP to restart shared care.**
* I am aware that medications for ADHD are not always easy to switch over in case of supply issues, and should my medication become unavailable I will contact the specialist provider who can advise my GP on what to prescribe.
* **If I require a dose change or have other issues related to ADHD, I will seek a review from a specialist service**.   
  **• If this is NHS, I will seek a referral from the GP to NHS Services**.  
  **• If diagnosis was made via RIGHT TO CHOOSE or IN THE PRIVATE SECTOR**, I will seek a review from the service that diagnosed me (*or if that service is no longer available, an alternative*). Because these are private organisations, they may charge you for this, which is their decision.
* I am aware that if the above agreement is breached or the GP surgery feels I am in breach of this agreement or the shared care protocol, the GP can end this agreement, and that the GP will no longer be responsible for issuing ADHD medications, and that there is no obligation on the GP to resume this agreement.
* The GP practice may alter the terms of this agreement in line with any changes to the regulation of medications for ADHD, or, due to pressures on the practice. Any changes will be communicated to patients.
* I can confirm I live within the practice boundary as defined on the practice website. I accept that if I move outside the practice area then the terms of this agreement will no longer apply.

This is intended to enable the patient to have local care provided by the practice without placing undue pressure on the GP practice to take on additional work. I accept that final interpretation of this agreement is entirely at the discretion of the GP practice.

I agree to the above terms in their entirety.

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| Name of patient: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| (If patient is under 16 years of age. this must be signed by parent or guardian: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Patients date of birth: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Patients address: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please return to the surgery either by paper or by electronic means.