**MIDODRINE for the treatment of Severe Orthostatic Hypotension due to Autonomic Dysfunction, Postural Orthostatic Tachycardia Syndrome (POTS)**

**or Inappropriate Sinus Tachycardia (IST)**

**Transfer of Prescribing Responsibility**

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| **Section A: To be completed by the initiating organisation / clinician INITATING ORGANISATIONS TO ADD LOCAL CONTACT DETAILS FOR SPECIALIST SERVICE (TEL / EMAIL) FOR QUERIES** | |
| **Patient Details:**  **Name:........................................ DOB: …./.…/.… Hospital No: …………………….. NHS No: ………………………..** | |
| **GP Practice Details:**  Name: ………………………………………  Address: ……………………………………  Tel no: ………………………………………  NHS.net e-mail: …………………………… | **Consultant Details:**  Consultant Name:.......................................................  Organisation Name:...........................................................  Clinic Name:……………………………………………  Address: ……………………………………………  Tel no: …...................... NHS.net email: ………………………… |
| Dear Dr…………  **This patient is on a midodrine for:** Severe orthostatic hypotension due to autonomic dysfunction / Postural Orthostatic Tachycardia Syndrome (POTS) / Inappropriate Sinus Tachycardia (IST) (delete as appropriate)  **I have supplied the first three months of therapy for this patient and the dose of midodrine is now stable. I am requesting your agreement to transfer the prescribing responsibility for this patient’s on-going treatment from …/…/… in accordance with the South East London Area Prescribing Committee (SEL APC) formulary recommendations.**  I will review the patient at least annually throughout treatment. The following investigations have been performed and are acceptable for transfer of care.   |  |  |  |  | | --- | --- | --- | --- | | **Test** | **Result** | **Date of test** | **Please repeat test in:** | | Supine Blood Pressure |  |  | Months | | Standing Blood Pressure |  |  | Months | | Sitting Blood Pressure |  |  | Months | | Serum Creatinine |  |  | Months | | Creatinine Clearance\* |  | | Aspartate Transaminase (AST) or Alanine Transaminase (ALT) |  |  | Months |   \*Estimate creatinine clearance (CrCl) using the Cockcroft-Gault equation  **Contact details of specialist nurse for GPs to access:**  Name: ………………………….. Tel no:……………………………. NHS.net email: …………………………  **Other relevant information**: ………………………………………………………………………………………………………………..   |  | | --- | | * I confirm that I have prescribed in accordance with the SEL APC guidelines * I confirm the patient has consented to treatment * I confirm that the patient has been made aware of the benefits and risks of midodrine therapy, including risk   of supine hypertension, and that they know how to seek medical help should symptoms occur.   * I confirm that patient and/or carer is able to monitor their BP while lying, sitting and standing at home * I confirm patient has access to specialist nursing support (including contact numbers) if unlicensed   **Signed:……………………………………. Name of Clinician:…………………………… Date: …………….** | | |

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| **Section B: To be completed and signed by the GP if NOT willing to take on prescribing responsibility and returned to the specialist clinician as detailed in Section A above.** |
| This is to confirm that I am not willing to accept the transfer of care of prescribing midodrine for this patient ***for the following reason***:  ……………………………………………………………………………………………………………….  **GP name: ………………………………GPsignature: ………………………………………………Date: ……/….…/…....**  ***(This transfer of care document should be reviewed in-conjunction with the drug screening checklist sent previously by the initiating clinician - if not received contact consultant named above for details)*** |