Please scan in to patient's GP medical record

Patients Name..... DoB.....
NHS number..... Specialist.....

Shared Care Guidelines
Growth Hormone in Children

BACKGROUND

Growth Hormone (GH) or somatropin is available as a biosynthetic and biosimilar growth hormone with a sequence identical to human pituitary GH and is of importance for the metabolism of lipids, carbohydrates and proteins. It stimulates linear growth and increases growth rate and also maintains a normal body composition.
Treatment with GH should always be initiated and monitored by a paediatrician with specialist expertise in managing growth hormone disorders in children.

1. A patient with confirmed GH deficiency and in an otherwise stable condition does not require frequent hospital supervision and will be reviewed in the endocrine clinic 2-3 times a year.

2. Biosynthetic GH has a good safety record and monitoring of response more frequently than every 3-6 months is not required. Dose adjustments may be required annually, and will be based on changes in height and weight and IGF 1 levels.

3. GH therapy is expensive and continuation has to be justified by objective evidence of accelerated growth rate and improvement of predicted final height. The Endocrinology department has facilities for this assessment and will provide regular updates on patients' response to treatment to GPs.

4. A minority of candidates for GH therapy have had, or continue to have complex health disorders requiring specialist management e.g. children with a brain tumour, complex midline defects and MPHD. GP and specialist must discuss each case individually in order to agree on a treatment and shared care strategy and agree as to when treatment with GH is most appropriate e.g. when the patient is in remission.

PRINCIPLES OF SHARED CARE

- Shared care is the mechanism of sharing patient care between primary and secondary care providers and assumes good communication between the patient, GP and hospital consultant and pharmacists.

- The aim of these shared care guidelines is to provide sufficient information to the GP to be confident to take on the clinical and legal responsibility for prescribing the drug treatment.

- The shared care guidelines will clearly outline the responsibilities of the GP, hospital consultant/specialist and the patient.

- The intention to share care with the GP should be explained to the patient/parent/carer by the specialist initiating treatment and an outline of responsibilities provided.

- Prescribing responsibility will only be transferred when the patient's condition is stable or predictable. This is usually at 3 – 6 months after initiation of treatment.

- The doctor who prescribed the medication legally assumes clinical responsibility for the drug and the consequences of its use.

- It would not be expected that a GP would decline to share prescribing on the basis of cost.

- The patient's best interest and the safe management of their treatment is paramount.

RESPONSIBILITIES

Consultant/Specialist Responsibilities

1. Undertake the necessary testing to **confirm a diagnosis** for which GH treatment is recommended, as indicated by NICE
2. To confirm that proposed therapy is not contra-indicated.
3. To seek funding approval (using the agreed proforma) from the patient's CCG for commencement of GH treatment and at annual intervals thereafter. The GP to be informed of the process and given Shared Care Guidelines to consider.
4. To ensure that the patient has been stabilised on any other drug therapy
5. To discuss the potential benefits, side effects and stopping criteria of treatment with the patient and carer.
6. Provide the patient/carer with up to date information on growth hormone treatment and the locally preferred products, in order for patient to decide on preferred method of administration. If the selected product is not licensed for the particular indication, discuss with the patient/carer their possible options and record in the patients notes.
7. Arrange training of patients and families on GH (usage, injection technique, safe storage and disposal of injection equipment and requirements for long distance travel) and provide a patient held record for monitoring.
8. To review the patient's growth and general condition at 3 to 6 monthly intervals. To include accurate height and weight measurements and bone age assessment as indicated, and determination of pubertal status. To undertake provocation testing and MRI as indicated, in order to make diagnosis. All patients on growth hormone treatment require plasma IGF-1 concentrations to be monitored at yearly intervals in children.
9. To provide the GP with information of the diagnosis and indication for GH therapy, outlining dosage, cost and product information. Products should be prescribed by brand to avoid confusion.
10. To provide GP and family with a written list of all current drug treatment.
11. To request of GP that necessary arrangements are made locally and fed back to the specialist centre to identify any possible barriers to treatment being commenced.
12. When funding is approved prescribe GH until patient/ carer are competent at administration and treatment is stabilised, for a minimum of 3 months.
13. To agree a transfer of prescribing date with the GP, and inform the CCG of this date.
14. To report adverse effects to the CHM. If the indication is unlicensed, all adverse effects should be reported even if a causal relationship is not known or if the adverse effect is already known about. http://www.mhra.gov.uk/Safetyinformation/Howwemonitorthesafetyofproducts/Medicines/TheYellowCardScheme/Informationforhealthcareprofessionals/index.htm
15. To review GH dosage guided by height velocity, weight/surface area, pubertal stage and plasma IGF-1 concentration.
16. To submit a continuation funding application to the CCG annually. On receipt of confirmed funding approval from the CCG, to advise the GP that the patient meets continuation criteria for growth hormone.
17. To advise the GP of alterations to dosage, after each clinic attendance.
18. To review associated drug therapy.
19. To ensure clear arrangements are in place for back up, advice and support, e.g. out of hours and/or when the specialist initiating treatment is not available.
20. To decide on the timing of cessation of treatment, reassessment, and transition to adult care for adult GH therapy.
21. To monitor outcomes as follows:

    - Growth velocity must be at least 50% of baseline level for years 1, 2 & 3.
    - PWS children – also take into consideration body composition when assessing ongoing response continued over leaf
    - Short, Medium and Long Term End Points of Growth Hormone Therapy in GHD Children (see table below)

	End Point	Rationale	Measure
Short Term	1. Growth acceleration	1. Assess response	1. Growth velocity must be at least 50% of baseline level for years 1, 2 & 3.
	2. Reduction in adipose mass	2. Assess response	2. Skinfold thickness where indicated
	3. Correct Dose	3. Optimise Therapy	3. IGF-1 and growth
	4. Vision and headaches	4. Possible Raised Intracranial Pressure	4. Fundoscopy
	5. Assessment of limp	5. Slipped femoral epiphysis	5. X ray
Medium Term	1. Bone maturation	1. Rate of skeletal maturation	1. 1-2 Yearly Bone age
	2. Pubertal Status	2. Early puberty or rapid progression	2. 6 monthly Tanner staging
	3. Correct Dose	3. Optimise therapy	3. IGF-1 and growth response. Return to Target Height within 6 years of therapy
	4. Thyroid status	4. Altered status or evolving endocrinopathy	4. Yearly thyroid function tests
	5. Other hormones	5. Evolving endocrinopathy	5. Gonadotroph and corticotroph function
	6. Metabolic Status	6. Insulin insensitivity	6. Fasting glucose and insulin
Long Term	1. Growth	1. Outcome	1. Final Height within Target Height of parents
	2. Bone mineralisation	2. GH effect on bone	2. DEXA Scan
	3. Malignancy Risk	3. Possible GH cancer link	3. Cancer registry
	4. Cardiovascular risk	4. Hyperinsulinism or GH effect (Long term GHD)	4. Fasting glucose and insulin, blood pressure, fasting lipids

General Practitioner/ Local Paediatrician/ Prescriber responsibilities

1. Consider the invitation from the hospital consultant to share the care of the patient as indicated in these shared care guidelines
2. Ensure that the Specialist's request to commence GH treatment has been approved by the CCG
3. Once local consideration of treatment has occurred, to feedback to the Specialist where there are concerns regarding the prescribing of GH.
4, Agree with the Specialist the date of transfer for prescribing, and inform the CCG of this date. Specialist will prescribe for a minimum of 3 months.
5. To prescribe GH therapy by brand name as part of a Shared Care Agreement, using the specific prescribing information provided by the specialist. At this point, to ensure that patient is aware of who is undertaking the monitoring and for how long GH will be prescribed before a review is been received Only put on repeat for defined periods of time and mark review date subject to Specialist report received and confirmed funding continuation letter from the CCG. If Specialist Report and CCG letter are not received, prescribing and care should be transferred back to the Specialist and CCG notified. It is advised that prescriptions are provided no more frequently than every 28 days days - larger supplies may be wasted if treatment is discontinued following Consultant review,
6. Reporting adverse effects of therapy to the Specialist or deputy.
7. Monitor patient's overall health and well-being.

8. To ensure that the family knows what significant adverse effects to report urgently and to whom they should report.
9. To monitor usage of GH.
10. To seek specialist advice promptly if there is any clinical suspicion of loss of efficacy.
11 To stop treatment on advice of specialist, or immediately if intolerable side effects occur provided it is safer to do so than to continue treatment.

If you wish to enter this Shared Care Agreement with the Specialist for this patient, please email WECCG.medicinesqueries@nhs.net **and the Specialist with your confirmation.**

If you have concerns regarding the prescribing of GH for this patient, please email WECCG.medicinesqueries@nhs.net **and the Specialist for advice.**

Clinical Commissioning Group

1. To provide funding approval for the commencement of GH and at annual review dates when criteria are met. Communicate funding decision to Specialist and GP.
2. To support GPs to make the decision whether or not to accept clinical responsibility for prescribing.
3. To consider an IFR application if the criteria are not met.
4. To support the Trust in resolving issues that may arise as a result of Shared Care

Patient / Parents / Carers' role

1. To ensure they have clear understanding of the treatment, review and stopping criteria.
2. To give the growth hormone as directed.
3. Share any concerns in relation to the treatment with the Specialist or GP.
4. Report any adverse effects to the Specialist or GP whilst taking the medication.
5. Attend booked appointments for review and monitoring whilst receiving growth hormone with both the GP and Specialist.
6. To ensure the safe, appropriate storage and disposal of waste GH and the devices.
7. Sign the Patient Agreement Letter.
8. Forward the prescriptions to the Homecare company on a timely basis

Contact Numbers

Princess Alexandra Hospital		Telephone
Switchboard		01279 444455
Consultant	Dr Balakumar	Via switchboard
Registrar	Endocrine Registrar	Via switchboard
Secretary	Frances Stride	john.biddulph@pah.nhs.uk or ring him on 01279827349 otherwise I will respond as soon as possible on my return.
Pharmacy	Medicines Information	01279 827054

Patient Support Groups

The Child Growth Foundation: 2 Mayfield Avenue, Chiswick, London W4 1PW Tel: 020 8994 7625
The Pituitary Foundation: (PitPat) of the Society for Endocrinology, 17/18 The Courtyard, Woodlands, Almondsbury, Bristol, BS12 4NQ Tel: 0117 927 3355

NICE APPROVED LICENSED indications for GH Therapy in Children

1. Growth hormone insufficiency/deficiency (GHD) causing short stature:
   - Idiopathic isolated GHD
   - Congenital hypopituitarism e.g. anomalies of the pituitary gland such as septo-optic dysplasia
   - Acquired hypopituitarism e.g. craniopharyngioma & post cranial irradiation or neuro-surgery or traumatic brain injury
2. Turner Syndrome (confirmed by chromosome analysis) causing growth disturbance
3. Chronic renal failure (CRF) causing growth disturbance. Post renal transplant is a discontinuation criterion.
4. Prader-Willi syndrome, PWS, (confirmed by chromosomal analysis or phenotype). Treatment of obese patients is not currently advocated due to safety concerns
5. Short stature homeobox-containing gene (SHOX) deficiency (confirmed by DNA analysis)
6. Small for Gestational Age (SGA) children with growth disturbance and failure to catch up growth by 4 years.

Any other indication (eg Noonan syndrome, and skeletal dysplasias, IGF 1 Deficiency for example due to neurosecretory dysfunction and CHARGE syndrome with short stature and IGF1 deficiency) would be outside of routine commissioning arrangements and funding applications can be made via the Individual Funding Request (IFR) where there is patient exceptionality.

INITIATION CRITERIA

See funding application proforma for initiation criteri.

STOPPING CRITERIA

Treatment with somatropin should be discontinued if **any** of the following apply:

- Growth velocity is less than 50% of baseline level for years 1,2 &3
- Final height is approached and growth velocity is less than 2 cm total growth in 1 year
- There are insurmountable problems with adherence
- Final height is attained

A positive response to any of the stopping criteria is an indication for treatment discontinuation, The Consultant should confirm this in writing to the GP and CCG following review.

Growth Hormone

Following training by a specialist nurse the carer or child will administer GH by subcutaneous injection each night, in order to mimic the normal physiology of GH secretion. The injection site should be rotated to avoid lipotrophy.

Growth Hormone Dosage and administration in Children

Refer to Summary of Product Characteristics (SPC) – Individual SPCs[5] doses differ slightly

INDICATION	GH DOSAGE (calculated in microcgrams/kg/day or mg/m^2/day) given as a daily subcutaneous injection	
	micrograms/kg/day	mg/m^2/day
GHD	23 - 39	0.7 - 1.0
Turner Syndrome	45 - 50	1.4
Chronic Renal Failure		
SHOX deficiency		
Prader-Willi Syndrome	35	1.0
SGA		

Cautions

- In diabetic patients, insulin dose may need to be adjusted on GH initiation

- Thyroid tests will be conducted as part of baseline tests in hospital. All follow up will be from hospital team.
- Disorders of epiphysis of the hip - monitor for limping.
- May increase clearance of drugs metabolised by cytochrome p450 3A4 e.g. anticonvulsants and ciclosporin
- Corticosteroids may inhibit growth promoting effects of somatropin
- Higher doses of somatropin may be needed with oral oestrogen replacement therapy.

- There have been reports of fatalities with the use of growth hormone in paediatric patients with PWS who had one or more of the following risk factors: severe obesity, history of respiratory impairment, sleep apnoea, or unidentified respiratory infection. Male patients with one or more of these factors may be at increased risk. Therefore PWS patients with the following risk factors:
  - severe obesity
  - history of respiratory impairment or sleep apnoea
  - unidentified respiratory infection

will be referred by the endocrine team to a paediatric respiratory physician for evaluation of upper airway obstruction before initiation of treatment with growth hormone. If there are signs of upper airway obstruction treatment should be ceased and referred again by endocrine team for a paediatric respiratory physician for evaluation.

Adverse Effects

Adverse effects	Symptoms/signs	Actions
Transient local skin reactions at injection site	Redness, inflammation	Rotate injection sites
Fluid retention, uncommon in children. More common in Turner Syndrome	Peripheral oedema	May subside spontaneously or dose reduction may be required - discuss with endocrine consultant
Arthralgia	Pain in joints	Start appropriate analgesia
Myalgia; may be related to the preservative m-cresol, a preparation without this preservative can be substituted	Pain or inflammation of voluntary muscle	
Hypo/Hyper-glycaemia	Hypo: hunger, nausea, sweating, weakness, faintness, confusion hallucinations, headache, cold sweat, piloerection, hypothermia, irritability, bizarre behaviour and fainting Hyper: thirst, polyuria, tiredness, and increased susceptibility to infections	Check blood glucose and if BM <3.5 or 8 mmol/L refer to consultant Endocrinologist.
Benign intracranial hypertension	Severe/recurrent headache, visual problems, nausea/vomiting	Stop treatment immediately and urgently discuss with Endocrine consultant, fundoscopy for papilloedema is recommended.

For further information on cautions, contra-indications and interactions please refer to the current British National Formulary and Summary of Product Characteristics.
http://www.medicines.org.uk/emc/

The safety record is excellent. Antibody formation can be detected but is rarely of physiological relevance.

Neoplasia: Extensive surveys have **not** suggested an increased tumour or leukaemia risk with GH therapy, compared with similar patients who have not received GH therapy when replacement doses are physiological in confirmed GHD. Supra-physiological doses have not been used in this situation.

What may be of more concern is the recent report from the UK that young adults treated with human pituitary GH up until 1985 had a higher mortality risk for colon cancer and non Hodgkin lymphomas than the general population (Swerdlow AJ, Higgins CD, Adlard P, Preece MA. Risk of cancer in patients treated with human pituitary growth hormone in the UK, 1959-85: a cohort study. Lancet 2002; 360: 273-7). It is however important to note that these data were collected on patients on high doses of human pituitary derived GH which may have also contained other growth factors. Although these data raise concern **they do not provide firm evidence of an association**. Long-term surveillance of patients receiving GH therapy irrespective of diagnosis is continuing through National Cancer Registries.

Prader Willi Syndrome: Prader-Willi Syndrome (PWS) is a rare genetic disorder with an incidence of approximately one in 10,000 births. In the first year of life it is characterised by hypotonia and failure to thrive, but in later years if energy intake is not restricted, severe obesity results. Other components of this syndrome include short stature which is now generally accepted to be associated with GHD. As obesity is associated with reduced GH responses on testing, it was argued that the GH abnormality in PWS was not the primary problem. More detailed neuroendocrine studies, however, revealed that the majority of individuals with PWS have GHD. Randomised controlled studies of r-hGH in PWS have demonstrated an increase in short term linear growth analogous to that seen in patients with GHD. The r-hGH dosing schedule is similar to that used in GHD. Further data on final heights are now becoming available and are similar to those observed in GHD patients

Although the value of increasing the stature of these individuals can be questioned, the effects of r-hGH treatment on body composition is perhaps of greater importance. Growth Hormone therapy leads to fat sparing and an increase in lean body mass. The latter is less obvious in PWS and is in contrast to the reports of increased muscle strength and agility. The observation of improved respiratory muscle function is of particular importance in these individuals.

To date the safety profile of growth hormone in PWS is similar to that observed in the GHD child. However, in severely obese PWS patients there appears to be a potential risk of sudden death associated with GH use (April 4, 2003. Addendum to the Pharmacia statement on recently reported cases of death in growth hormone treated patients with PWS, January 7, 2003). For this reason, we do not currently give GH to severely obese patients with PWS.

Choice of GH/somatropin product

- There are no significant therapeutic differences between the preparations available but the choice of product should be made on an individual basis after informed discussion between the responsible clinician and the patient and/or their carer and may be determined by a number of factors including patient preference for injection techniques, advantages and disadvantages of the products available, and the likelihood of adherence to treatment.
- Ideally a licensed product should be selected; if this is not possible it should be discussed with the patient and or their carer and recorded in the notes.
- Parents or older children can be taught to self-administer the injections. Regular review of injections techniques is important to ensure accuracy and compliance.
- It is important that the brand of preparation used should be only changed by the supervising consultant since training in a new injection technique may be required. It also avoids duplication of products should side effects occur.

The commissioner has requested that only 3 company product choices to be discussed with child and parent/carer. These to be chosen by taking into consideration the cheapest product in primary care

Products of choice for West Essex patients:
Omnitrope®
Norditropin®
Saizen® – only for needle phobic patients
Humatrope® - only for SHOX deficiency if Omnitrope and Norditropin declined

	Product license for use in children					
Product	GDH children	Turner syndrome	Chronic renal insufficiency	Prader-Willi syndrome	Growth disturbance in SGA	SHOX deficiency
Omnitrope®	Yes	Yes	Yes	Yes	Yes	No
Norditropin®	Yes	Yes	Yes	No	Yes	No
Saizen®	Yes	Yes	Yes	No	Yes	No
Humatrope®	Yes	Yes	Yes	No	Yes	Yes

Somatropin (Growth Hormone) Cost in Primary Care for Brands and Preparations available in the UK				
Company	**Brand**	**Presentation**	**Strengths of Presentation (mg)**	**Primary Care Cost (per mg of somatropin)**
Pfizer	**Genotropin®**	Pen Cartridge	5.3mg and 12.0mg	£17.38
		GoQuick® prefilled multi -dose pen	5.3mg and 12.0mg	
		MiniQuick® single dose syringes	0.2mg up to 2mg (in increments of 0.2mg)	
Sandoz	**Omnitrope®**	Pen Cartridge	5mg and 10mg	£17.35
Eli Lilly	**Humatrope®**	Pen Cartridge	6mg, 12mg and 24mg	£18.00
Ferring	**Zomacton®**	Vial for needle free device	4mg	£19.92
		Vial for syringe	10mg	
Ipsen	**Nutropin Aq®**	Pen Cartridge	10mg	£20.30
Novo Nordisk	**Norditropin®**	SimpleXx® Pen Cartridge	5mg, 10mg and 15mg	£21.27
		Nordiflex® prefilled multi -dose pen	15mg	£23.18
Merck Sereno	**Saizen®**	Pen Cartridge	6mg, 12mg and 20mg	£22.87
		Click.easy® cartridge	8mg	
Prices accessed from NHS Dictionary and Medical Devices July 2014				

Medical Information

BSPED - www.bsped.org.uk
NICE - www.nice.org.uk
ESPE – www.eurospe.org

Date of preparation: June 2014 Date of review: June 2016

Prepared by Dr Balakumar Consultant Paediatrician, PAH

Angela Kenny, Senior Commissioning Pharmacist, West Essex CCG

Approved by Area Prescribing Committee June 16th 2014

With thanks to Herts Valley Clinical Commissioning Group and Tower Hamlets Shared Care Guidelines

GP response to Shared Care Agreement

(only complete & send if NOT participating in shared care)

This shared care agreement has been approved by the Medicines Management Optimisation Programme Board

Patient Name:	NHS No:
Consultant:	Medicine requested for shared care: **Hydroxycarbamide**

I will **NOT** be undertaking the GP responsibilities as described in the agreed shared care agreement. My clinical reasons for declining shared care for this patient are listed in the box below:

Yours sincerely

{GP name}

{Surgery}

Please send a copy of this response to:
1. The Specialist/consultant requesting shared care
2. **ANONYMISED COPY OF THIS FORM ONLY** to the E-MAIL: **tpa-tr.ClinicalPharmacy@nhs.net**

(sending a copy of this form to the PAH pharmacy will help to identify any inappropriate requests for shared care e.g. indication not covered, hospital monitoring requirements not fulfilled. It will also help to inform the CCG Medicines Optimisation Team of the reasons shared care is not being undertaken by GPs allowing for changes to be made in future updates to improve patient safety)

P14064

The Princess Alexandra Hospital NHS
NHS Trust

Hamstel Road
Harlow, Essex
CM20 1QX

Tel: 01279 444455

Information for patients:

SHARED CARE: Agreement information and confirmation

Patient name:

.....

Medicine:

.....

We would be grateful if you would take time to read this information as it will help us work with you to manage your condition and ensure safe prescribing of the specific medicine listed above.

What is a Shared Care Agreement (SCA)?

A Shared Care Agreement (SCA) enables the care you have for a specific condition to be shared between the hospital and your GP.

The agreement means that the medicine the hospital has started, can be continued by your GP, so you won't have to visit the hospital to collect your medicine.

The SCA gives information on your medicine, guidance on the prescribing and monitoring responsibilities for your consultant (in the hospital), your GP and you. For an SCA, to work everyone involved must understand it and communicate effectively.

Your consultant and your GP will need to sign the agreement and if you agree to this approach, we would ask you to sign this letter, to indicate your agreement to have your care managed in this way.

How does shared care work?

Your consultant and GP share responsibility for your care.

The consultant is a specialist in your condition and will start prescribing your medicine, making sure it is suitable for you. There will come a point in your treatment when you may not need to be monitored by the consultant as often and this monitoring can be done by your GP.

Once your GP has agreed to the SCA, they will be able to prescribe the same medicine for you at the dose recommended by the consultant.

The organisation which regulates GPs, the General Medical Council, says that 'when a GP prescribes a medicine, the GP needs to satisfy themselves that the prescription is needed, appropriate for the patient and within the limits of their competence'.

So, your GP can only issue a prescription if the consultant and you keep to the responsibilities you have agreed (see below). If responsibilities are not kept or if the GP no longer feels it is safe to prescribe the medicine, he/she will explain the reasons to you and your consultant, then prescribing responsibilities will be transferred back to the hospital.

What do I need to do to ensure the SCA can continue?

- **Attend hospital outpatients**
  You must still attend the hospital for regular reviews as directed by your consultant (these may be less frequent than before). If you do not attend your hospital appointments, your GP will not be able to continue issuing prescriptions for this medication.
- **Attend GP appointments**
  You must attend any appointments you have with your GP in relation to this medicine, so they can look after you effectively.
- **Have blood tests as you have been advised to**
  Your consultant should have informed you

continued overleaf

If and how often you need to have blood monitoring tests. You can usually have your blood taken at an appropriate clinic and not need to go to the hospital.

- If you do not have the blood monitoring tests as advised by your consultant, your GP will no longer be able to issue you with prescriptions as it would not be safe to do so.

What do I do if I am having side-effects to the medicine?

Your consultant should have informed you of the common side-effects to expect and what to do if you experience them. If you think you may be having side-effects from a medicine report these directly to your consultant. Your GP may need to seek advice from your consultant before issuing you with another prescription; this is to ensure it is safe for you to continue on the medication.

What if my disease symptoms change or get worse?

Report any changes in disease symptoms or circumstances that could affect management of your disease to your consultant.

What about the other medicines I take?

Inform your GP and the consultant of all other medicines you are taking, including those you may have bought yourself. Do not take new medicines (including those you could buy) until you have discussed this with your pharmacist, GP or consultant.

If you would like to go ahead with a shared care agreement for the specific medication identified on page 1, please sign below to confirm that you:

- Understand the shared care agreement.
- Are happy to have your care for this aspect of your health managed by a shared care agreement.
- You agree to attend regular review appointments as requested.
- You agree to have blood tests as required.

Patient's signature .....

Date .....

Print name .....

If at any point in time you would like this shared care agreement to stop, please talk to your GP.