**Direct Oral Anticoagulants (DOACs) for Stroke prevention in (non-valvular) Atrial Fibrillation (AF)**

**Transfer of Prescribing Responsibility**

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| **Patient Details:**  **Name:.**     **...................................................….......... DOB:**      **/**     **/**       **Hospital Number:**      **……………………………… Address:**      **…………………………………………………….**  **NHS Number:**      **…………………………………….. …………………………………………………………………………..** | |
| **GP Practice Details:**  Name:      ……………………………………  Address:      ……………………………………  Tel no:      ………………………………………  Fax no:      ……………………………………..  NHS.net e-mail:      …………………………… | **Consultant Details:**  Consultant Name:      ............................................................  Organisation Name:      ..........................................................  Clinic Name:      ………………………………………………..  Address:      ……………………………………………………  Tel no:      …................................................…………………  Fax no:      ………………… NHS.net email:      …………………… |
| Dear Dr      ………….  This patient has been initiated on the following DOAC in accordance withSouth London guideline for stroke prevention in atrial fibrillation for long term (unless specified below under other relevant information).   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **DOAC initiated** | **Tick selected** | **Date initiated** | **Dose on transfer** | **Date of next review** | | Apixaban |  |  |  |  | | Edoxaban |  |  |  |  | | Dabigatran |  |  |  |  | | Rivaroxaban |  |  |  |  |   **I have now supplied the first three months of therapy for this patient and am writing to transfer the prescribing responsibility for this patient’s on-going anticoagulation from**      **/**     **/**     .  This transfer of care document should be reviewed in conjunction with the screening checklist and notification sent previously by the initiating clinician. If this has not been received contact the consultant named above for details.  All patients receiving DOAC therapy for non-valvular AF long term should be reviewed at least annually throughout their treatment. Please refer to the prescribing document of individual DOAC for more details.  **Monitoring:**   |  |  |  |  | | --- | --- | --- | --- | | **Test** | **Result** | **Date of test** | **Please repeat test in:** | | Serum Creatinine |  |  | …     .months | | Creatinine clearance (CrCl\*) |  | | Haemoglobin |  |  | 12 months | | ALT or AST (delete as appropriate) |  |  | 12 months |   \*eGFR should NOT be used to guide dosing decisions. Creatinine clearance must be estimated using the [Cockcroft-Gault equation calculator](http://www.mdcalc.com/creatinine-clearance-cockcroft-gault-equation/#from-the-creator) or refer to the South London creatinine clearance information sheet.  Other relevant information:      ………………………………………………………………………………………………………..  ………………………………………………………………………………………………………………………………………………..  **Antiplatelet Therapy**   |  |  | | --- | --- | | Is the patient receiving concomitant antiplatelet therapy?  YES  NO | | | Antiplatelet(s) in use: | Indication: | | Should antiplatelet therapy be withheld whilst patient on anticoagulation?  YES  NO  Comments (including plan for antithrombotic therapy) | |  |  | | --- | | I confirm that I have prescribed in accordance with the local stroke prevention in AF guidelines  I confirm that the patient has been made aware of the benefits and risks of DOAC therapy, including risks  of both major and minor bleeding, and that they know how to seek medical help should bleeding occur.  I confirm that an anticoagulation card and/or medic-alert bracelet has been provided  I confirm the patient has consented to treatment  For female patients of child-bearing age: I have explained the risks of falling pregnant whilst on this treatment  and recommended appropriate contraceptive measures are taken  **Signed:**      **……………………………………. Name of Clinician:**      **…………………………… Date:**      **……….** | | |

In the event that there are any concerns regarding the acceptance of the prescribing responsibility for this medication please contact the anticoagulation / thrombosis clinic via: