



## Shared Care agreement for Melatonin in the Management of Sleep Disorders in Children and Young People with Neurodevelopmental Disorders, and in adults aged over 18 with a learning disability (off-label use)

For Bassetlaw: This Shared Care agreement **ONLY** applies for patients under the care of DBTHFT paediatrics and RDaSH

### Template letter to primary care prescriber

Dear Prescriber

Patient's name: ..... DOB: ..... NHS No. ....

Address: .....

Your patient is being stabilised on treatment with: **(tick as appropriate)**

- Melatonin 2mg MR tablets
- Adaflex tablets
- Melatonin 1mg/ml oral solution SF
- Ceyesto oral solution
- Slenyto MR tablets

on a dose of \_\_mg daily.

This treatment can be prescribed by primary care prescribers under the Traffic Light System under the "shared care" arrangements. This shared care guideline has been approved by the Doncaster Place & Bassetlaw Place Medicines Optimisation Committee (PMOC).

We have chosen to use this medication because **[insert reasons]**.

As part of shared care arrangements please can you undertaken a medication review and monitor compliance, adherence, response, and side effects to therapy annually. Will you also please undertake to prescribe for your patient?

The prescriber will be responsible for ensuring monitoring of the patient on the medication being prescribed as per this guideline.

**Please acknowledge you are happy to take on shared care by completing and returning the slip below to above address or by secure email to .....**

Do not hesitate to contact us if you have any concerns.

Yours sincerely

Clinician's Name.....

Clinician's Title .....



**Shared Care agreement for Melatonin in the Management of Sleep Disorders in Children and Young People with Neurodevelopmental Disorders, and in adults aged over 18 with a learning disability (also off-label use)**

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**Prescriber response form**

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*The prescriber is responsible*

*for monitoring the patient on the medication being prescribed*

**Patient's name:** ..... **DOB:** ..... **NHS No:** .....

**Address:** .....

I AGREE to take on shared care of this patient

I DO NOT AGREE to take on shared care of this patient

Signed .....

Practice.....

Date.....