# SHARED CARE AGREEMENT

**CNS Stimulants and other drugs for Attention Deficit Hyperactivity Disorder (ADHD) in Children**

(Atomoxetine, Dexamfetamine, Methylphenidate hydrochloride)

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<th>Status:</th>
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<td>31.01.2014</td>
<td>Dr Peter Coleman</td>
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**Document Author**

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Signed: Dr Andrew Watson

Date:

Job Title: General Practitioner  
Consultant Paediatrician

Approval at DAC: September 2013

Trust Executive Committee date: 16th September 2013

CCG date: Friday 18th October 2013

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**Version Control History:**

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<td>Dr Peter Coleman</td>
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<td>Logo Added</td>
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NB: This Shared Care Agreement relates to Isle of Wight NHS hereafter referred to as the Trust.

This shared care guideline has been produced to support the seamless transfer of prescribing and patient monitoring from secondary to primary care and provides an information resource to support clinicians providing care to the patient. It does not replace discussion about sharing care on an individual patient basis.

This guideline was prepared using information available at the time of preparation, but users should always refer to the manufacturer's current edition of the Summary of Product Characteristics (SPC or “data sheet”) for more details.

The Trust holds full responsibility for any adverse events preventable by monitoring stated within the agreement at all times that prescribing continues within the limits set by the agreement.
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1. INTRODUCTION

Medications for ADHD will only be initiated by an appropriately qualified healthcare professional with expertise in ADHD after a comprehensive assessment. Continued prescribing and monitoring of medications may be performed by GPs, under shared care arrangements (NICE, 2006b).

This shared care guideline has been produced to facilitate the seamless transfer of patient treatment from secondary to primary care, and it provides an information resource to support clinicians providing care to the patient. It does not replace discussion about transfer of care on an individual patient basis, and patients will still remain under the overall care of secondary care specialists.

This guideline was prepared using information available at the time of preparation, but users should always refer to the manufacturer’s current edition of the Summary of Product Characteristics (“data sheet”) for more details.

Aims of ADHD service

- The secondary care specialist will be responsible for the prescribing and monitoring of initial dose(s) while treatment is being titrated. The specialist will identify when the patient is suitable for shared care and invite the patient’s GP/practice to participate in the shared care.
- Prescribing responsibility will only be transferred when it is agreed by the specialist and the patient’s primary care prescriber that the patient’s condition is stable i.e. the treatment is clinically effective and is free from serious side effects.
- Prescribing responsibility will only be transferred to the patient’s primary care prescriber once the prescriber has agreed to each individual case.

Therapy should only be started for recognised indications for specified lengths of time. Maintenance of patients first stabilised in the secondary care setting should be properly controlled.

- The service to the patient is convenient
- The need for continuation of therapy is reviewed regularly
- The therapy is discontinued when appropriate
- The use of resources by the National Health Service is efficient

2. INDICATIONS/PATIENT SELECTION

This shared care agreement is for the management of ADHD when drug therapy is required after an appropriate duration of non-drug interventions including behavioural support, parenting support and educational support; it is to cover children from ages 6-16 or up to 18 if they were still at school.

Methylphenidate and Dexamfetamine are stimulant drugs licensed in the treatment of severe Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD) and Hyperkinetic Disorder (HKD) as part of a comprehensive treatment plan.
Atomoxetine is licensed for the treatment of ADHD in children aged 6 years and over, and in adolescents as part of a comprehensive treatment plan.

(Comprehensive treatment programme – defined to include psychological, education & social measures).

3. PREPARATIONS

Approved generic name - **Methylphenidate**
Brand Name - Concerta XL, Equasym XL, Medikinet, Medikinet XL, Ritalin
Form and strength: standard release and modified release preparations

Approved generic name – **Atomoxetine**
Brand Name - Strattera
Form and strength: 10mg, 18mg, 25mg, 40mg, 60mg and 80mg capsules

Approved generic name - **Dexamfetamine**
Form and strength: 5mg tablets

4. SAFETY ISSUES

4.1 Dose (see BNF or SPC for current information)

The dose is to be titrated by the secondary care doctor in line with NICE and BNF guidelines

**Methylphenidate:**

**Plain – Ritalin® and Medikinet®:** Child over 6 years initially 5mg once or twice daily e.g. with or after breakfast and lunch, increasing if necessary in weekly intervals of 5-10mg up to a maximum of 60mg per day in 2 to 3 divided doses.

In some children rebound hyperactivity may occur if the effect of the drug wears off in the evening. An additional dose later in the day may eliminate this difficulty but may disturb sleep.

**Concerta XL®:** Child over 6 years initially 18mg once daily (in the morning), increasing if necessary in weekly increments of 18mg up to a maximum of 54mg once daily.

Note: Total daily dose of 15mg of standard release formulation is considered equivalent to Concerta XL® 18mg once daily.

**Equasym XL®:** Child over 6 years, initially 10mg once daily (in the morning before breakfast), increasing if necessary in weekly intervals to a maximum of 60mg daily.

**Medikinet XL®:** Child over 6 years, initially 10mg once daily (in the morning with breakfast), adjusted according to response at weekly intervals to a maximum of 60mg daily.

**Atomoxetine:**
Atomoxetine is licensed in children from the age of 6 years.

**Dosing in children/adolescents up to 70kg body weight:**

Initially a total daily dose of approximately 0.5mg/kg per day. This should be maintained for a minimum of 7 days, before titrating upwards according to clinical response and tolerability. Maintenance dose is approximately 1.2mg/kg per day (depending on the patient’s weight and available dosage strengths of atomoxetine).

No additional benefit has been demonstrated for doses higher than 1.2mg/kg/day. The safety of doses above 1.8mg/kg has not been systematically evaluated.

**Dosing of children/adolescents over 70 kg body weight:**

Initial dose of 40mg per day. This should be maintained for a minimum of 7 days, before titrating upwards according to clinical response and tolerability. Maintenance dose is 80mg per day.

Maximum licensed dose is 100mg/day; however no additional benefit has been demonstrated for doses higher than 80mg. The safety of single doses over 120mg and total daily doses above 150mg have not been systematically evaluated.

Note: Atomoxetine should be administered as a single daily dose in the morning with or without food.

**Dexamfetamine (Dexedrine®):**

The usual starting dosage for children aged 3-5 years is 2.5mg a day, increased if necessary by 2.5mg a day at weekly intervals; for children aged 6 years and over, the usual starting dose is 2.5mg 2 to 3 times per day increasing if necessary by 5mg per day at weekly intervals. The usual upper limit is 20mg a day though some older children have needed 40mg or more for optimal response. Maintenance dose should be given in 2 to 4 divided doses.

4.2 Contra-indications (see BNF or SPC for current information)

- Known sensitivity to methylphenidate, dexamfetamine or atomoxetine
- Cardiovascular disease or moderate/ severe hypertension
- Hyperexcitability or agitated states
- Hyperthyroidism
- History of drug or alcohol abuse
- Glaucome
- Pregnancy or breastfeeding
- Concomitant use of atomoxetine with monoamine oxidase inhibitors

4.3 Cautions (see BNF or SPC for current information)

- Mild hypertension (contra-indicated if moderate or severe). Monitor BP and pulse rate
- History of epilepsy (discontinue if convulsions occur).
- Tics and Tourette’s syndrome
- Monitor growth in children – height and weight (see below).
- Porphyria.
• In adults, urinary hesitancy or retention should be considered possible sequelae of usage
• In psychotic children, it may exacerbate behavioural disturbances and thought disorder
• Avoid abrupt withdrawal
• Manufacturer recommends periodic complete and differential blood and platelet counts
• Allergic reactions have been reported uncommonly
• Data on safety and efficacy of long-term use is not complete

4.4 Common Side Effects (See Appendix A, BNF or SPC)

General side effects – see appendix A

CSM Warnings with Atomoxetine in 2005

• Rare Risk of Hepatic Disorders

The Committee on Safety of Medicines has reported rare but sometimes severe cases of hepatic disorder associated with the use of Atomoxetine. The risk is estimated at below 1 in 50,000 patients treated.

Advice to Prescribers

Due to the seemingly idiosyncratic nature of these reactions routine monitoring of liver function is unlikely to be helpful in minimising the risk, and is therefore not recommended. Patients should be made aware of the risk and asked to report any warning signs immediately. All suspected hepatic reactions should be investigated. Atomoxetine should be discontinued in patients with jaundice or laboratory evidence of hepatic injury, and should not be re-started. Atomoxetine remains under intensive safety surveillance by the CSM through the yellow card reporting scheme, as a ‘black triangle’ drug at the time of writing.

• Suicidal thoughts in children and adolescents treated with Atomoxetine

In September 2005 the Medicines and Healthcare products Regulatory Agency (MHRA) reported on an analysis of 12 clinical trials which identified an increase in the rate of suicidal thoughts/behaviour in a small number of Atomoxetine treated individuals compared with those receiving the placebo.1 suicide attempt and 5 reports of suicidal thoughts, in a sample of 1,357 children/adolescents were reported, there were no completed suicides.

Advice to Prescribers

Patients on Atomoxetine should be monitored for signs of depression, suicidal thoughts or suicidal behaviour and be referred for appropriate treatment if necessary. Patients and Parents should be informed about the risk and watch for any clinical worsening, irritability or agitation, suicidal thoughts or behaviour or other unusual changes in behaviour.

4.5 Drug Interactions

Methylphenidate
May inhibit the metabolism of coumarin anticoagulants, some anticonvulsants, phenylbutazone and tricyclic antidepressants. The dosage of these drugs may need to be reduced

Caution with pressor agents and MAOIs

**Dexamfetamine**

- Should not be used with MAOI's nor initiated within two weeks of cessation of treatment with an MAOI as may precipitate a hypertensive crisis
- Adrenoreceptor blocking agents e.g. propranolol, lithium and α methyltyrosine may antagonise the effects of dexamfetamine. Concurrent use with beta blockers may precipitate a hypertensive crisis
- Use with tricyclic antidepressants may increase risk of cardiovascular side effects
- Acute dystonias have been noted with concurrent administration of haloperidol
- Phenothiazines may inhibit the actions of dexamfetamine
- Dexamfetamine may inhibit the absorption of ethosuximide, phenobarbital and phenytoin

**Atomoxetine**

- Atomoxetine can be used initially in combination with methylphenidate as trials show no cardiovascular effects beyond that caused with methylphenidate alone
- Caution with pressor agents or drugs affecting NA, e.g. venlafaxine, mirtazepine
- Should not be used with MAOI's nor initiated within two weeks of cessation of treatment with an MAOI as may precipitate a hypertensive crisis
- Caution with drugs which prolong the QT interval e.g. anti-arrhythmics, erythromycin, tricyclic antidepressants, lithium etc
- Caution in patients on high dose nebulised/systemic salbutamol
- Caution with drugs which lower the convulsive threshold e.g. tricyclic antidepressants & neuroleptics.

**4.6 Routine Monitoring**

- The patient will be reviewed and monitored 6 monthly; the results will be communicated to the GP. The following will be monitored:
  - Height, weight and appetite, recorded on a growth chart
  - Blood pressure and pulse, recorded on a centile chart
  - Refer patients who develop symptoms of cardiac complications for prompt specialist cardiac evaluation.
  - Development of new, or worsening pre-existing, psychiatric symptoms.
  - Update from other aspects of treatment plan, e.g. family therapy, behaviour therapy.

**5 RESPONSIBILITY OF SECONDARY CARE TEAM (i.e. CAMHS/ Consultant Paediatricians)**

- Diagnosis following full assessment
- Undertake full history, documenting: past and present medical and psychiatric disorders or symptoms, family history of sudden cardiac death, unexplained death; and accurate pre-treatment height and weight on a growth chart.
- Assess and document baseline cardiovascular status, including blood pressure and heart rate, before prescribing and seeking specialist cardiac advice if appropriate.
- Development of individual care plan detailing pharmacological and non-pharmacological interventions.
- Initiation and stabilisation of drug therapy (where indicated).
- Patient/family education of ADHD and drug therapy.
- Liaison with school providing information about ADHD and drug therapy.
- To look out for signs of misuse and abuse of medication.
- Ensure shared care agreements are in place before transfer of treatment and that the patient and family are clear on who is monitoring what.
- Review and monitor the following on a 6 monthly basis and communicate these results to the GP:
  - Height, weight and appetite, recorded on a growth chart
  - Blood pressure and pulse, recorded on a centile chart
  - Refer patients who develop symptoms of cardiac complications for prompt specialist cardiac evaluation.
  - Development of new, or worsening pre-existing, psychiatric symptoms.
  - Update from other aspects of treatment plan, e.g. family therapy, behaviour therapy.
- Inform the GP of any changes to the medication regime. Specify any products/dose or frequency changes.
- Inform GP of patient’s failure to attend appointment and provide advice on stopping medication as necessary.
- Take responsibility for stopping the drug or to agree aftercare when the patient reaches 18 years of age.

6 RESPONSIBILITY OF GP

Once a stable medication regime has been established, prescribing of drugs may be transferred to primary care with agreement.

- Ensure that shared care arrangements are in place before initiating treatment.
- To provide repeat prescriptions after stabilisation. Prescriptions for methylphenidate and dexamfetamine should be restricted to 30 days supply.
- To contact the Specialist/Secondary care team if there is deterioration in behaviour.
- To report adverse drug reactions to the Specialist.
- Refer patients who develop symptoms of cardiac complications for prompt specialist cardiac evaluation.
- To look out for signs of misuse and abuse of medication i.e. lost prescriptions, monitor through IT systems.
- To act upon results communicated by Specialist.
- To review the appropriateness of prescribing for patients who have not been seen by a specialist for over one year.
- To ensure all relevant staff within the practice are aware of the shared care guidelines.
- GP to ensure patient nominates pharmacy for collection of medication.

7 RESPONSIBILITY OF PATIENT
• To provide written notification for further repeat prescriptions, giving the surgery at least 3 working days’ notice.
• Informing the school when the child is on any medication and whether it involves a lunchtime dose or not.
• To attend regular follow-up appointments (medication cannot be prescribed without regular follow-up).
• To inform GP/Consultant of all medicines (including OTC preps) that the child is currently taking.
• To report any unusual symptoms/adverse effects to GP/Consultant.
• To ensure that the child takes the medication safely, appropriately and on time.
• To safely store the medication.
• To have read and understood the product’s patient information leaflet
• To nominate preferred pharmacy for collection of medication.

8 FURTHER INFORMATION - ABUSE POTENTIAL

• Minimised by consideration of family circumstances on initiation (as currently).
• Minimised by smaller quantities of controlled drug given on each prescription (monthly now recommended as national good practice, and longer scripts will be queried by community pharmacists as a new national requirement). GP prescribing is often the safest and most practical way for patients to receive ongoing monthly medication. Posting of CD scripts is not recommended, unless a full audit trail exists.
• Minimised by CAMHS/Paediatrician communicating ‘defaulters’ for specialist review urgently to GP, as above.
• Yellow ‘warning stickers’ suggested for patient notes where there is concern about possible drug diversion or misuse.
• Atomoxetine does not cause changes in the Nucleaus Accumbens associated with other known drugs of abuse. It may therefore be a preferred option where there are clinical grounds for suspecting abuse or potential abuse in the prescribing of stimulants such as Methylphenidate or Dexamphetamine.
Side Effects

Appendix A

See SPC for full list and details. Note: All clinicians should use up-to-date children’s BP monitoring charts (see Appendix B) and UK centile growth charts.

NB the NICE Technology appraisal no 98 2006 states that no statistically significant differences with respect to adverse effects were found between dexamfetamine and methylphenidate.

<table>
<thead>
<tr>
<th>Side effects</th>
<th>Medicines associated</th>
<th>Who should respond/report</th>
<th>Effect</th>
<th>What to do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea and Vomiting.</td>
<td>Methylphenidate Atomoxetine</td>
<td>GP Consultant Parent</td>
<td>Usually transient</td>
<td>Stop drug if persists for longer than a few days or becomes untenable</td>
</tr>
<tr>
<td>Drowsiness, Headache, Effects on vision</td>
<td>Methylphenidate Dexamfetamine</td>
<td>GP Consultant Parent</td>
<td>Usually transient</td>
<td>Stop drug if persists for longer than a few days or becomes untenable</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Dexamfetamine Methylphenidate</td>
<td>GP Consultant Parent</td>
<td>Usually poor settling, especially in a child who was a poor sleeper before. May be transient.</td>
<td>If not transient: Move the evening dose to 6pm first/or try reducing the 4pm dose.</td>
</tr>
<tr>
<td>Somnolence</td>
<td>Atomoxetine</td>
<td>GP Consultant Parent</td>
<td>Usually transient, occurs early in therapy. May be helped by taking dose with food to</td>
<td>Be sure to distinguish between somnolence and reduction in ADHD symptoms. Usually transient but can continue for some weeks. Stop drug if becomes untenable.</td>
</tr>
<tr>
<td>Condition</td>
<td>Medication</td>
<td>Prescribing Authority</td>
<td>Management</td>
<td></td>
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</tr>
<tr>
<td><strong>Early morning waking</strong></td>
<td>Atomoxetine</td>
<td>GP Consultant</td>
<td>Stop drug if persists for longer than a few days or becomes untenable</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Parent</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Usually transient</td>
<td></td>
</tr>
<tr>
<td><strong>Abdominal pain</strong></td>
<td>Atomoxetine</td>
<td>GP Consultant</td>
<td>Stop drug if persists for longer than a few days or becomes untenable</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Parent</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Usually transient – may be more common with BD dosing</td>
<td></td>
</tr>
<tr>
<td><strong>Irritability &amp; mood swings</strong></td>
<td>Atomoxetine</td>
<td>GP Consultant</td>
<td>If problematic contact monitoring consultant for further advice</td>
<td></td>
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<td></td>
<td></td>
<td>Parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Usually transient</td>
<td></td>
</tr>
<tr>
<td><strong>Poor appetite</strong></td>
<td>Dexamfetamine</td>
<td>GP Consultant</td>
<td>Give the drug after the meal. Make sure the child eats a lot at night when medication has worn off. Monitor height and weight. If child has moved down through a centile consider stopping the drug. Refer back to monitoring consultant.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methylphenidate</td>
<td>Parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Atomoxetine**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Less common</strong></td>
<td>Methylphenidate</td>
<td>GP Parent</td>
<td>Check, if necessary do an ECG. Check pulse after every change of dose and opportunistically. Stop if resting pulse &gt; 100 Avoid other drugs which ↑ QT interval</td>
<td></td>
</tr>
<tr>
<td>Tachycardia, Arrhythmias, Palpitations QT interval prolongation (atomoxetine only)</td>
<td>Dexamfetamine</td>
<td>GP Parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Atomoxetine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Raised blood pressure</strong></td>
<td>Dexamfetamine</td>
<td>GP Parent</td>
<td>Recheck again in a few days (unless very high). Check within published parameters. Monitor every 6 months and opportunistically. Stop if necessary.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methylphenidate</td>
<td>Parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tics</strong></td>
<td>Dexamfetamine</td>
<td>GP Consultant</td>
<td>Stop drug if persists for longer than a few days. Refer to monitoring consultants.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methylphenidate</td>
<td>Parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dyskinesia</strong></td>
<td>Dexamfetamine</td>
<td>GP Consultant</td>
<td>Stop drug. Refer to monitoring consultant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methylphenidate</td>
<td>Parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>Medication</td>
<td>Responsible Parties</td>
<td>Description</td>
<td>Action</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Psychosis: visual or auditory</td>
<td>Dexamfetamine</td>
<td>GP, Consultant, Parent</td>
<td>May be transient child complains of hearing voices or seeing things and is frightened by them.</td>
<td>Reduce or stop drug. Refer to monitoring consultant.</td>
</tr>
<tr>
<td></td>
<td>Methylphenidate</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convulsions</td>
<td>Dexamfetamine</td>
<td>GP, Consultant, Parent</td>
<td></td>
<td>Stop drug and do an EEG. Refer to monitoring consultant.</td>
</tr>
<tr>
<td></td>
<td>Methylphenidate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Atomoxetine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergic reactions including angioneurotic oedema &amp; urticaria</td>
<td>Atomoxetine</td>
<td>GP, Consultant, Parent</td>
<td></td>
<td>Stop drug if severe or troublesome and refer to monitoring consultant</td>
</tr>
<tr>
<td>Leucopenia, Thrombocytopenia And anaemia</td>
<td>Methylphenidate</td>
<td>GP, Consultant, Parent</td>
<td>Excessive bruising nosebleeds</td>
<td>Stop drug. Full blood count with platelets. Reversible on discontinuation of therapy. Incidence 0.001%</td>
</tr>
<tr>
<td>Hepatic Disorder</td>
<td>Atomoxetine</td>
<td>GP, Consultant, Parent</td>
<td>Jaundice or evidence of suspected hepatic reaction</td>
<td>Stop Drug. Full blood count and liver function. Incidence 1 in 50,000 patients treated</td>
</tr>
</tbody>
</table>
Suicidal Thoughts | Atomoxetine | GP Consultant Parent | Irritability agitation suicidal thoughts or unusual changes in behaviour. | Stop Drug. Urgent referral to monitoring consultant

**Some patients lose weight early in therapy especially at higher doses, however weight and height rates after 2 years are near normal**

Appendix B

**Vital Signs in Children**

<table>
<thead>
<tr>
<th>Age</th>
<th>Pulse</th>
<th>Respirations</th>
<th>Average BP in mmHg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonate</td>
<td>120-170</td>
<td>30-50</td>
<td>Newborn</td>
</tr>
<tr>
<td>1 year</td>
<td>80-160</td>
<td>26-40</td>
<td>6months - 1year</td>
</tr>
<tr>
<td>2 years</td>
<td>80-130</td>
<td>20-30</td>
<td>2 years</td>
</tr>
<tr>
<td>4 years</td>
<td>80-120</td>
<td>20-30</td>
<td>6-7 years</td>
</tr>
<tr>
<td>6 years</td>
<td>75-115</td>
<td>20-26</td>
<td>9-10 years</td>
</tr>
<tr>
<td>8 years</td>
<td>70-110</td>
<td>18-24</td>
<td>12-13 years</td>
</tr>
<tr>
<td>10 years</td>
<td>70-110</td>
<td>18-24</td>
<td>13-14 years</td>
</tr>
<tr>
<td>Adolescence</td>
<td>60-110</td>
<td>12-20</td>
<td></td>
</tr>
</tbody>
</table>

1. Signature

The Practice commits to participate in the delivery of the Shared Care for ADHD
Re: ADHD shared care agreement

Patient’s details

Dear Dr,

I have seen this patient in clinic and believe that he/she is suitable for treatment under the Shared Care arrangements.

I have initiated this patient on ………………………………………………………………………………………………………..

………………………………………………………………………………………………………………………………………………

(Details of regime)

with the diagnosis of ……………………………………………………………………………………………………………

and have prescribed and monitored this patient in our clinic for a period of …..months. I am satisfied this patients condition and medication is stable, and is a suitable candidate for Shared Care Prescribing within Primary care.
Conditions are correct to hand over routine prescribing and monitoring of this patient's treatment as per drug guideline attached.

Please complete the form below and fax back to …………………………….

I thank you in anticipation.

Yours Sincerely

Dr

Specialist Consultant Physician
Copy to Patient / Hospital Notes / GP

Shared Care Monitoring re. ADHD

Fax back to: Specialist Consultant Physician

Delete as applicable

I agree to take over prescribing and monitoring responsibility for this patient as per shared care guidelines.

In light of exceptional circumstances I am not willing to undertake shared-care for this patient because

………………………………………………………………………………

Reasons for not accepting patients into Primary Care will lead to a discussion with the consultant and the reasons will be monitored by clinical governance leads.

Patient name: __________________________
Date of Birth: __________________________

Isle of Wight Clinical Commissioning Group - Shared Care Agreement v6 31.01.2014
Yours sincerely

Dr

Practice address

I ………………………………………… Patient / Carer (delete as appropriate) agree to take responsibility for the following:

- Informing the school when the child is on any medication and whether it involves a lunchtime dose or not
- To attend regular follow-up appointments (medication will not be prescribed if regular follow-up appointments are missed)
- To inform GP/Consultant of all medicines (including OTC preps) that the child is currently taking
- To report any unusual symptoms/adverse effects to GP/Consultant
- To ensure that the child takes the medication safely, appropriately and on time
- To safely store the medication
- To have read and understood the product’s patient information leaflet
- To nominate preferred pharmacy for collection of medication

Signed ………………………………………… Date ………………………..