Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Agreement for
Lithium (for B&NES)
(Please prescribe by brand name: Priadel, Camcolit®, Liskonum®, Li-Liquid®)
BNF 4.2.3

Traffic Light Status: **Amber**

Lithium should not be routinely initiated in Primary care. Lithium should be initiated and stabilised within secondary care. Once the patients condition is clinically stable, it can be appropriate for GPs to resume prescribing with the guidance of an AWP approved Shared Care Agreement.

AREAS OF RESPONSIBILITY FOR THE SHARING OF CARE

This shared care agreement outlines suggested ways in which the responsibilities for managing the prescribing of lithium can be shared between the specialist and general practitioner (GP). If the GP is not confident to undertake shared care, then s/he must let the specialist know within 3 weeks of receipt of this request. In such an event, the total clinical responsibility for the patient for the diagnosed condition will remain with the specialist.

Sharing of care assumes effective communication between the specialist, GP and patient. The intention to share care should be explained to the service user by the doctor initiating treatment. Other Healthcare Professionals involved with the patients care also have a role in safe lithium management [(2)(3)(5)]. It is important that patients are consulted about treatment and are in agreement with it. Patients receiving lithium must be under regular follow-up, which provides opportunities to discuss drug therapy.

The prescriber legally assumes clinical responsibility for the drug and the consequences of its use.

This agreement for lithium must be read in conjunction with the Procedure for the prescribing and monitoring of lithium in AWP.

U:\Lithium procedure.doc

Table 1 RESPONSIBILITIES

AWP Specialist team responsibilities [(1, 3,4, 5, 6,7)]
1. Assess patient, establish diagnosis and develop care plan. Ensure care plan contains correct contact details for care co-ordinator/ key worker and consultant psychiatrist.
2. To undertake physical health screen and assessment when patient is admitted to mental health services.
3. Ensure that arrangements of appropriate blood tests are made. Blood tests may be taken at the GP surgery providing appropriate communication with the GP and the GP is in agreement with this. Secondary care is responsible for the interpretation and monitoring of these blood test results for the first 3 months of treatment.
4. Be fully aware and understand the advice given as per the NPSA lithium alert issued in December 2009 http://www.nrls.npsa.nhs.uk/alerts/?entryid45=65426&p=2
5. Provide written information on lithium to patient / carer so that an informed decision on taking lithium and consent to treatment can be made. Inform patient of symptoms of toxicity and to report immediately to doctor / healthcare professional. Treatment should be discontinued immediately on the first signs of toxicity.
6. Record in the care plan that the 'Checklists' as per page 14 and 17 of the Procedure for the prescribing and monitoring of lithium in AWP have been done. Record in progress notes that baseline monitoring has been done as per NICE guidance CG38 (see monitoring below)
7. To prescribe the first 3 months of lithium treatment, prescribing by brand name.

8. Issue a lithium therapy patient pack (can be sourced from pharmacy or from NPSA website) and ensure it is completed and explained to the patient. Advise the patient to carry the lithium alert card at all times whilst on lithium treatment and to present the record book to healthcare professionals involved in the prescribing / dispensing of lithium. Document this is done in patient records on Rio.
9. Inform patients to tell community pharmacists that they take lithium before they purchase medicines
10. To ensure that the patient is fully informed about their treatment. For women of child bearing potential, this should also include a discussion about contraception and any plans they may have for pregnancy (as lithium is a known teratogen).
11. Inform patient to maintain adequate fluid intake and avoid dietary changes which reduce or increase sodium intake, particularly be aware of sweating (e.g. after exercise, hot climates, fever) or if they are immobile for long periods or in the case of the elderly, develop chest infections or pneumonia.
12. Inform patient to report any conditions leading to salt/water depletion e.g. vomiting or diarrhoea.
13. Discuss the proposal of lithium agreement with the patient. If possible obtain consent (verbal is fine) and document in notes. If patient declines then please document this too.
14. Obtain patients agreement that he/she will attend clinic/GP practice for bloods/ tests to be done relating to lithium treatment and to sign the patient agreement monitoring form (end of document)
15. Ensure that the GP has a copy of the 'lithium agreement' and a signed copy of the 'Agreement signature sheet for lithium'. The dose, formulation and brand of lithium must be given
16. To liaise with the GP and agree how the relevant tests are to be communicated between themselves and the patient.
17. Review results of any baseline tests and relay any abnormal findings to the GP with appropriate advice
18. Check there are reliable systems to ensure blood test results are communicated efficiently between laboratories and prescribers
19. To ensure that prescribing outside the market authorisation is in line with best clinical practice.
20. Forward copy of care plan to GP – including clear information around target serum lithium level and advice on action required when lithium level is outside range.
21. To prescribe the first 3 months of lithium treatment.
22. Monitor for response and adverse drug reactions; to report ADRs to MHRA & GP
23. Communicate promptly with the GP when treatment is changed.
24. To review the patient and treatment at least once a year until the patient is discharged from the mental health service where this is possible.
25. To review patient / provide advice as requested via the GP or Primary Care Liaison Service as necessary.
26. Advise the GP on when to adjust the dose, stop treatment (assuming no relapse in patients condition), or consult with the specialist.
27. Inform GP of concurrent therapy (as this may interact with other medication patient gets from GP).
28. Inform GP if any appointments are not attended.
29. Ensure that clear backup arrangements exist for GPs to obtain advice and support. (See 'Back-up advice and support' for contact details).
30. Any verbal communication between primary and secondary care should be confirmed in writing

General Practitioner responsibilities [1,4,5,7,8]
1. Reply to the request for lithium agreement within 3 weeks of receipt of request using the 'Agreement signature sheet for lithium'. 2. Be fully aware and understands the advice given as per the NPSA lithium alert issued in December 2009 http://www.nrls.npsa.nhs.uk/alerts/?entryid45=65426&p=2 3. To take over prescribing after 3 months of treatment at the dose, formulation and brand requested by the specialist. 4. If the GP decides not to prescribe lithium, it should still be added to the patients repeat

medication as a "non issued' item for information and safety purposes. **For EMIS** The quantity should be set to *0 or 1. On the dose line it should read: *'Hospital prescribing only. Do not prescribe'*. **For TPP SystmOne**, it is entered using the red question mark icon on the medication screen. Once entered, this appears at the bottom of the repeat template screen in a separate in a separate section (and a different colour), however it does not appear on the repeat prescription screen which may be used by prescription clerks. For Vision Enter as a 1:1 repeat, put quantity as 1 tablet, on the dose line it should read: *'Hospital prescribing only. Do not prescribe'*.

This process should also be done during the stabilisation period before the GP takes over the prescribing.

5. Be alert to drug interactions, especially diuretics, NSAIDs, ACEIs and ,A2RBs (See Table 4)
6. Adjust the dose / stop drug as advised by the specialist. Please note that lithium should not be stopped suddenly. It should be discontinued over 4 weeks. If it is stopped suddenly there is a 50% chance of relapse within 3 months.
7. Review patient as agreed in the patients care plan and lithium agreement.
8. Inform specialist team of any change in the patient's medication that may interact with medication patient receives from the specialist team.
9. Check patients bloods are up to date. The prescriber who is signing the prescription for lithium is responsible for ensuring that the relevant tests and monitoring of lithium therapy is undertaken as per NICE guidance CG38.
10. Check there are reliable systems to ensure blood test results are communicated efficiently between laboratories and prescribers
11. Prescribe and monitor levothyroxine if required.
12. Monitor patients overall health and compliance. Re-enforce use of the "Lithium Therapy Record Book", re-issue if required.
13. Check patient for adverse effects and signs of toxicity at each appointment and inform any significant adverse effects to the specialist..
14. Remind patient to maintain adequate fluid intake and avoid dietary changes which reduce or increase salt/ water intake e.g. be aware of the impact of vomiting or diarrhoea, sweating (e.g. after exercise, hot climates, fever) or if they are immobile for long periods or in the case of the elderly, develop chest infections or pneumonia
15. To request specialist review or seek specialist advice when necessary. (see ' Back-up advice and support for contact details)
16. Once the patient has been discharged from specialist MH services, advice may be sought from the Primary Care Liaison Service on any aspect of patients mental health that is of concern to the GP (see ' Back-up advice and support for contact details)
17. Report adverse events to the specialist and MHRA.
18. Any verbal communication between primary and secondary care should be confirmed in writing

Patients responsibilities [1,3,4,5,6]
1. Agrees to attend clinic / GP practice for bloods/tests relating to lithium treatment to be done and signs the patient agreement monitoring form (below)
2. Report to the specialist or GP if he or she does not have a clear understanding of the treatment 3. To be aware of the risks and symptoms of toxicity associated with lithium treatment. 4. Share any concerns in relation to treatment with lithium medication. 5. Read the Lithium Therapy Patient Pack, carry the "Lithium Alert Card" at all times and present the "Lithium Therapy Record Book" to healthcare professionals involved with prescribing or dispensing lithium and at any hospital specialist appointments or in-patient stays . 6. Tell your pharmacist that you take lithium before you buy any medicines 7. Inform the specialist and GP of any other medication being taken (e.g. diuretics, NSAIDs,ACEI, A2RAs), including over-the-counter products. In these cases, lithium dosage should be closely monitored and reduction of dosage may be necessary 8. Report any adverse effects or warning symptoms to the specialist or GP whilst taking lithium e.g. polyuria or polydipsia. 9. To maintain adequate fluid intake and avoid dietary changes which may affect salt/ water

intake. Inform the specialist and GP if any e.g. diarrhoea, vomiting, severe dieting or sweating occurs.

10. 8. Notify specialist services and GP if/when the medication is stopped.

Primary Care Liaison Service (PCLS) responsibilities
1. Accept referrals by registered GPs in line with DoH guidance.
2. To advise the GP on appropriate action regarding any issues they may have on patients management regarding shared care.
3. To try and resolve the issue(s) raised by the GP or to refer to the specialist team as appropriate.
4. Rapid & prioritised specialist mental health assessment with recommendation/s for care & treatment within multiple care pathways.
5. Determination of the nature & severity of mental health needs with consequent sign posting and pathway facilitation
6. Provide rapid and accessible ongoing support & advice to the non-specialist workforce

Primarily, this 'agreement for lithium' is between the Specialist consultant and the GP, with consent of the patient, but other healthcare professionals e.g. the community pharmacist, have roles in safe lithium therapeutic management:

Community pharmacist responsibilities [1, 3,5]

1. Be fully aware and understands the advice given as per the NPSA lithium alert issued in December 2009 http://www.nrls.npsa.nhs.uk/alerts/?entryid45=65426&p=2
2. Pharmacy staff are responsible for taking reasonable steps to ensure that it is safe to dispense lithium to a service user prescribed this drug in accordance with the above NPSA advice .
3. When a prescription for lithium is received, the pharmacist must ask the patient to see their lithium therapy record book and check that a lithium level has been done in the last three months and it is within the therapeutic range. This must be done prior to dispensing.
4. Counsel patient on safe use of lithium, to include potential signs of toxicity and side effects and the need to maintain a consistent fluid intake
5. The NPSA alert states that as a principle, therapy should not be withheld, in the absence of lithium levels if the service user is fit and well.

MONITORING REQUIREMENTS [7,8]

All patients initiated on lithium by AWP will have baseline monitoring completed by AWP as per relevant guidance before lithium treatment is started. The prescriber who is signing the prescription for lithium is responsible for ensuring that the relevant tests and monitoring of lithium therapy are undertaken as per the NPSA alert [5] and results are known when starting and continuing lithium treatment [3,5].

Table 2

When	By whom	Parameters
Pre-treatment	AWP Specialist team	Ca^{2+},TFTs,eGFR,Weight, *ECG & BP,
Four to a maximum of seven days after starting treatment, serum lithium levels should be measured.	AWP Specialist team	*Lithium plasma level.

When stable dose has been reached	By AWP Specialist team until GP takes over (after 3 months)	Lithium plasma level
Routine	GP	Lithium level every 3 months. TFTs, Ca^{2+} and eGFR every 6 months. Weight annually. *ECG & BP if clinically indicated. Lipid profile (in all those over 40 even if no other indication or risk), plasma glucose, smoking status and alcohol use & BP as part of annual review (NICE CG38)
If dose is changed	GP	Check levels weekly until four weeks after stabilisation at the new level, and then three monthly testing may be resumed.

*Notes:

Lithium levels - Lithium has a narrow therapeutic range necessitating blood levels between 0.4-1.2mmol/L.The lower end of this range is used for elderly and infirmed patients and the upper end for younger patients, particularly those being treated for an episode of mania. Clinicians should aim for levels of 0.6-0.8 mmol/L, with higher levels possibly being of benefit for patients with predominantly manic symptoms. Rarely 1.2mmol/L may be used

Cardiac function / **ECG** – ECG should be done at the start if there are risk factors for or existing cardiovascular disease; may need more frequent monitoring in those with cardiovascular disease or risk factors for it.

Weight – at start and when needed if the patient gains weight rapidly. Drug treatments to promote weight loss are not recommended.

Full blood count – only if clinically indicated.

***Results and referral for advice**

Table 3

When	Parameter	Normal range
Significant weight gain	> 10lb (~4.5kg) Offer dietary advice and advise regular aerobic exercise (as appropriate).	As per individual patient. Recommend annual follow-up by GP.
Raised Ca^{2+} Hypercalcaemia can cause renal stones, osteoporosis, dyspepsia, hypertension and renal impairment	Raised from upper threshold May indicate hyperparathyroidism. If evidence of hypercalcaemia, suggest PTH, vitamin D, urine creatinine, calcium and phosphate with repeat bone profile. Should be taken at the same time as one of the serum lithium measurements. Seek advice from AWP specialist.	Corrected 2.1 – 2.65 mmol/L
Raised Thyroid stimulating hormone (TSH)	Patients should be euthyroid before starting treatment with lithium. Thyroid antibodies may also be needed if clinically indicated. Bloods should be taken at the same time as one of the serum lithium measurements.	TSH: 0.3 – 5.5 µIU/mL Free T_4: 12-22 pmol/L Free T_3 : 3.9-6.8 pmol/L

	Hypothyroidism is easily treated with levothyroxine ; TFTs usually return to normal when lithium is discontinued. Seek advice from AWP specialist if necessary.	
Reduced eGFR	Renal function should be normal before starting treatment with lithium. May indicate lithium toxicity. Seek advice from AWP specialist	See Table NICE CG 73 Reduced eGFR (<60 ml/min/1.73 m2 or > 5 ml/min/1.73 m2 in 1 year)
Significant thirst & polyuria, fine tremor, gastrointestinal effects.	Often dose (plasma level) related. Fine hand tremor - consider propranolol for lithium-induced tremor. Polyuria may occur more frequently with twice daily dosing - repeat lithium level and consider once daily dosing.	Target serum level depends on age, any concurrent medication and mental state of patient. Rarely 1.2mmol/L may be used
Raised Li level (levels must be taken 12 hours post dose, otherwise clinical value is lost).	> 1mmol /L (unless specified by the specialist). Lithium levels of >0.8mmol/L are associated with a higher risk of renal toxicity.	Target serum level depends on age, any concurrent medication and mental state of patient. Rarely 1.2mmol/L may be used.
Starting ACEI, diuretic or NSAIDs which may affect Li+ level, or after change in dose/ brand of lithium therapy.	Repeat Li+ level and eGFR 3 to 4 days after change in dose/brand or initiation. Monitor more frequently in first month if loop diuretic is started (interaction may not be an issue).	0.4mmol/L – 1.2mmol /L
Evidence of clinical deterioration, abnormal results, signs of toxicity (see Table 5 below), concurrent infection, significant change in sodium/ fluid intake	Repeat Li+ level. Treatment should be discontinued during any intercurrent infection and should only be reinstituted after the patient's physical health has returned to normal Seek advice from AWP specialist.	

Interacting drugs:

Lithium has a narrow therapeutic index, so pharmacokinetic interactions with other drugs can precipitate lithium toxicity. There must be effective communication between all healthcare practitioners involved with patients on lithium therapy. This will ensure the impact of interacting medicines is considered when clinical decisions are made.
Please note that some drug/drug interactions may result in lithium toxicity at therapeutic serum concentrations. Main interactions which may increase lithium levels are:

Table 4

ACEI	Can reduce thirst which can lead to mild dehydration and increase renal sodium loss causing increased sodium reabsorption by the kidney and hence increased Li levels - up to a 4 fold increase (7-fold in the elderly). Can take several weeks to develop. Risk increased in those with heart failure, dehydration and renal impairment.
A2RAs	Care is needed when co-prescribed with lithium
Diuretics	Can reduce renal clearance of lithium. Thiazides are worse culprits than the loop diuretics: Li levels usually rise within 10 days of a thiazide being prescribed. Risk with loop diuretics can take up to a month for Li levels to rise.
NSAIDs	NSAIDs inhibit the synthesis of renal prostaglandins hence reducing renal blood flow and possibly increasing renal reabsorption of sodium and hence lithium. Aspirin does not usually affect serum lithium levels. Ibuprofen is usually safe for short term use on a 'when required' basis but should be used cautiously if other analgesics (e.g. paracetamol) are not appropriate. Check if patient is taking OTC products.

Others:
Drugs that may *increase* lithium levels:
Alcohol, dehydration, sodium chloride, systemic steroids.

Drugs that may *decrease* lithium levels:
Theophylline
Caffeine
Sodium bicarbonate containing products e.g. non-prescription antacids or urinary alkalinising agents.
Diuretics (osmotic and carbonic anhydrase inhibitors)

Interactions causing neurotoxicity:

Antipsychotics (although the combination can be useful)

Methyldopa

Triptan derivatives

Serotonergic antidepressants such as SSRIs (although the combination can be useful)

Verapamil / Diltiazem

Carbamazepine

Diet and concomitant minor illnesses which may increase lithium levels:
Nausea/vomiting or other conditions leading to salt/water depletion
Excessive sweating leading to sodium loss and retention of lithium by renal system
Dietary changes in sodium intake

Symptoms of neurotoxicity which can also occur at therapeutic levels:

Table 5

Symptoms
Paraesthesia
Ataxia
Vomiting
Diarrhoea
Increasing anorexia
Tremor
Cognitive impairment
Nausea
Uncontrolled eye movement
Slurred speech
Coma

MEDICATION DETAILS

Supporting information - Please also refer to the Summary of Product Characteristics (SPC) for lithium: www.medicines.org.uk and the current version of the BNF.

Table 6

Licensed indication [7,8]	1. the management of acute manic or hypomanic episodes. 2. the management of episodes of recurrent depressive disorders where treatment with other antidepressants has been unsuccessful. 3. the prophylaxis against bipolar affective disorders. 4. control of aggressive behaviour or intentional self harm.
Formulations available [8]	**Lithium carbonate:** Priadel® m/r 200mg & 400mg tablets (usual brand); Others include:Camcolit ® f/c 250 & 400 tablets; Liskonum® m/r f/c 450 tablets; **Lithium citrate:** Li-liquid ® oral solution 509mg/5mL (Li^+ 5.4mmol/ 5mL) Li-liquid® oral solution 1.018g/5ml (Li^+ 10.8mmol/5mL) Please note that each 5mL dose of 509mg/5ml of lithium citrate is equivalent to 200mg of lithium carbonate. **Priadel liquid ®** Lithium citrate 520mg/5ml (Li+ 5.4mmol/5mL) Please note that each 5mL dose of priadel liquid is equivalent to 204mg lithium carbonate.
Dose & frequency [4,8]	Usual range is 400mg to 800mg at night adjusted to achieve a serum-lithium concentration of 0.4 – 1 mmol/litre.
Administration & dose titration [1] [4] [7] [8]	Lithium treatment should only be initiated after careful clinical evaluation and discussion of the risks and benefits of medication with the patient. Lithium must be prescribed by brand as bio-availability varies widely between the different lithium products available. Lithium is usually prescribed as Priadel but please check if you are unsure. Liquids containing

	lithium citrate are sometimes prescribed. Each 5.4mmol of lithium citrate is roughly equivalent to 200mg of lithium carbonate. Changes in the brand of liquid or tablets or swapping between liquid and tablets require careful monitoring of the serum lithium level. Any change in the brand of liquid or tablets or swapping between liquid and tablets requires the same precautions as initiation of treatment. The starting dose is usually 400mg to be taken at night (200mg in the elderly). The dose is titrated according to the target serum level usually between 0.4mmol/l to 1mmol/l - bloods taken 12 hours post dose. Doses may be as high as 1400mg. For tablet preparations the dose is usually given as a single dose at night, for liquid preparations the dose may be split to twice a day.
Intended duration of treatment [1,6]	Depends on response & tolerability**.** Full benefit may not occur for 6 to 12 months. In those with a positive response, treatment is likely to be long-term (approx 5 years).
Contraindications [7]	1 Hypersensitivity to lithium or to any of the excipients. 2 Cardiac disease 3 Cardiac insufficiency. 4 Severe renal impairment. 5 Untreated hypothyroidism. 6 Breast-feeding. 7 Patients with low body sodium levels, including for example dehydrated patients or those on low sodium diets. 8 Addison's disease. 9 Brugada syndrome or family history of Brugada syndrome
Special warnings and precautions for use [4,7]	Caution should be exercised to ensure that diet and fluid intake are normal in order to maintain a stable electrolyte balance. This may be of special importance in very hot weather or work environment. Infectious diseases including colds, influenza, gastro-enteritis and urinary infections may alter fluid balance and thus affect serum lithium levels. Treatment discontinuation should be considered during any intercurrent infection Elderly patients are particularly liable to lithium toxicity and may exhibit adverse reactions at serum levels ordinarily tolerated by younger patients. Caution is also advised since lithium excretion may be reduced in the elderly due to age related decrease in renal function Lithium therapy should not be used during pregnancy, especially during the first trimester, unless considered essential. It is recommended that lithium is discontinued shortly before delivery and re-started a few days post-partum. Please ask your local Medicines Information service for more information. Caution is advised if lithium is co-administered with other drugs that prolong the QT interval or that lower the seizure threshold.
Side effects [1,4,7,8]	Side effects are usually related to serum lithium concentration and are less common in patients with plasma lithium concentrations below 1.0 mmol/l. The adverse reactions usually subside with a temporary reduction or

	discontinuation of lithium treatment. Mild gastrointestinal effects such as nausea, a general discomfort and vertigo, may occur initially, but frequently disappear after the first few days of lithium administration. Fine hand tremors, polyuria and mild thirst may persist. Blood and lymphatic system disorders : Leucocytosis. Endocrine disorders: Euthyroid goitre and/or hypothyroidism and thyrotoxicosis. Lithium-induced hypothyroidism may be managed successfully with concurrent levothyroxine (about 5% of patients treated with lithium become hypothyroid). Hypercalcaemia, hypermagnesemia, hyperparathyroidism have been reported. Metabolism and nutrition disorders : Weight increase, hyperglycaemia. Psychiatric disorders: Confusion. Nervous system disorders : Ataxia, hyperactive deep tendon reflexes, slurred speech, dizziness, nystagmus, stupor, coma, myasthenia gravis, giddiness, dazed feeling, memory impairment, vertigo, dysarthria, impaired consciousness, myoclonus, abnormal reflexes, convulsions, benign intracranial hypertension, extrapyramidal disorders. Cardiac disorders: Arrhythmia, mainly bradycardia, sinus node dysfunction, peripheral circulatory collapse, hypotension, ECG changes such as reversible flattening or inversion of T-waves and QT prolongation AV block, cardiomyopathy. ECG changes occur in about 5% of patients treated with lithium. Gastrointestinal disorders: Abdominal discomfort, taste disorder, nausea, vomiting, diarrhoea, salivary hypersecretion, dry mouth, anorexia. Skin and subcutaneous tissue disorders : Folliculitis, pruritus, papular skin disorders, acne or acneform eruptions, aggravation or occurrence of psoriasis, allergic rashes, alopecia, cutaneous ulcers. Musculoskeletal and connective tissue disorders: Muscle weakness. Renal and urinary disorders: Polydipsia and/or polyuria and nephrogenic diabetes insipidus. Long-term treatment with lithium may result in permanent changes in kidney histology and impairment of renal function. High serum concentrations of lithium including episodes of acute lithium toxicity may aggravate these changes. *Rare cases* of nephrotic syndrome have been reported. Other: Peripheral oedema. Reproductive: Sexual dysfunction. Senses: Dysgeusia, blurred vision, scotomata. If any of the above symptoms appear please seek specialist advice.
Drug interactions [4,7]	See interactions above
Monitoring	See monitoring requirements above

Advice to patient	Consider stopping lithium for up to 7 days if they become severely ill with a metabolic or respiratory disturbance. Please also see 'Patients Responsibilities'
Other practical issues [1]	Lithium tablets cannot be crushed or chewed.

BACK-UP ADVICE AND SUPPORT

CONTACT DETAILS

Table 7

Name	Tile / Role	Telephone	Email	Fax
	Specialist Consultant			
Bethan Shepherd	Formulary Pharmacist	07775562391	Bethan.shepherd@awp.nhs.uk	01225 362795
	Care coordinator			
Primary Care Liaison Service: **B&NES** 8am – 8pm then Intensive service	Intensive and Primary Care Liaison – Hillview Lodge	01225 371480		01225362799
Primary Care Liaison Service: **Bristol** 8am – 8pm then Intensive service	Intensive and Primary Care Liaison – interim to Speedwell then to Callington Road	0117 9195670		0117 9195625
Primary Care Liaison Service: **North Somerset** 8am – 8pm then Intensive service	Intensive and Primary Care Liaison – Long Fox Unit	01934 836406		01934 836405
Primary Care Liaison Service: **South Gloucestershire:** 8am – 8pm then Intensive service	Intensive and Primary Care Liaison – Bybrook Lodge, Blackberry Hill Hospital	01173 787960		0117 3787941
Primary Care Liaison Service: **Swindon** 8am – 8pm then Intensive service	Intensive and Primary Care Liaison – Sandalwood Court	01793 835787		01793 836817

Primary Care Liaison Service: Wiltshire 8am – 8pm then Intensive service	Intensive and Primary Care Liaison – Green Lane and at Fountain Way	**North Wiltshire** (Green Lane Hospital): 01380 7311341 **South Wiltshire** (Fountain Way): 01722 820372		01380 731295 01722 820376

REFERENCES:

1 Effective Shared Care Agreement (for the prescribing of lithium) Suffolk NHS Trust July 2010

2 Effective Shared Care Agreement for Lithium Therapeutic Management North Staffordshire NHS Trust, Stoke on Trent NHS Trust Dec 2010. Review Dec 2012.

3 Procedure for the prescribing and monitoring of lithium in AWP.

4 Shared Care Agreement Theresa Turner AWP Specialist Pharmacist for BNSSG Dec 2009

5 Patient Safety Alert, Safer Lithium Therapy, NPSA/2009/PSA005

6 NICE Clinical Guidance 38 The management of bipolar disorder in adults, children and adolescents, in primary and secondary care Issue date: July 2006

7 Summary Product Characteristics www.medicines.uk.org

8 BNF 63 March 2012

Document details: Prepared by Bethan Shepherd, Formulary Pharmacist, AWP Mental Health NHS Trust Final February 2013

Original template developed by MTRAC in January 2004 for local adaptation and adoption

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Patient Agreement Monitoring Form

I name of patient date of birth agree to attend the clinic / GP practice to allow the necessary tests relating to lithium treatment to be taken.

I agree that if I cannot attend an appointment for whatever reason, I will let the specialist / GP practice know.

Signed:_____

PRINT:_____