**The Apples Medical Centre** Version 1 **Date 31st July 2025**

**Shared Care Agreement for ADHD Management**

**Between:**

The Apples Medical Centre

East Mill Lane

Sherborne

Dorset

DT9 3DG

And

[Consultant's Name]
[Consultant's Department]
[Hospital/Clinic Name]
[Address]
[Postcode]

**Purpose:**

This agreement outlines the shared care arrangements for the management of patients with ADHD, ensuring safe and effective care through collaboration between primary and secondary care providers.

**Responsibilities:**

1. **Consultant Responsibilities: (Consultant Psychiatrist registered/Paediatrician registered with the GMC)**
	* Diagnose and stabilise the patient on ADHD medication.
	* Provide the initial prescription and ensure the patient is stable on the medication.
	* Conduct annual reviews of the patient's condition and treatment.
	* Manage any medication shortages and provide alternatives as necessary.
	* Communicate any changes in the patient's treatment plan to the GP

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1. **GP Responsibilities:**
	* Prescribe ADHD medication once the patient is stabilised and meets the criteria outlined in this agreement.
	* Monitor the patient's ongoing health and medication adherence.
	* Refer the patient back to the consultant for annual reviews or if any issues arise.
	* Provide the patient with information about their treatment and shared care arrangements.
2. **Patient Responsibilities:**
	* Attend all scheduled appointments with both the GP and consultant.
	* Adhere to the prescribed medication regimen.
	* Report any side effects or concerns to their healthcare provider promptly.

**Criteria for Shared Care:**

* The patient must be diagnosed and stabilised on medication by the consultant.
* The patient must be seen annually by the consultant for a review.
* The consultant is responsible for managing medication shortages and providing alternatives.

**Communication:**

* All parties agree to maintain open and timely communication regarding the patient's care.
* Any changes in the patient's treatment plan will be communicated promptly to ensure continuity of care.

**Agreement Duration:**

This agreement will remain in effect until [insert end date] or until terminated by either party with [insert notice period] notice.

**Signatures:**

By signing this agreement, all parties agree to the terms and responsibilities outlined above.

[Consultant's Name] (Consultant Psychiatrist registered/Paediatrician registered with the GMC)
[Date]

[GP's Name]
[Date]

[Patient's Name]
[Date]