Referral for Paliperidone Long Acting 3 Monthly Injection (LA3I)

This form must be completed before an initial supply of paliperidone 3 monthly LA3I can be supplied from pharmacy. Questions 1 - 4 MUST be completed.

Paliperidone LA3I is currently permitted within SSSFT for the maintenance treatment of schizophrenia only in adult patients who are clinically stable on 1-monthly paliperidone palmitate injectable product and do not require dose adjustments. For ALL requests that fall outside of this the form should be submitted to either the Chief Pharmacist or Medical Director for approval or refusal.

Patients Name:	**Unit No.:**	**Date of Birth:**
Male / Female:	**Unit/Team:**	**Consultant:**

1. Diagnosis: (delete as appropriate)
Schizophrenia / Bipolar Affective Disorder / Schizo Affective Disorder /
Other……

2. Is the patient stabilised on paliperidone monthly for a period of at least 4 months and does not need any dose adjustments and there have been no ongoing side effects of concern? **Yes / No**

3. Has the patient agreed to this change of medication and has consented to deltoid injection only? **Yes / No / Not yet discussed / Still under discussion**

4. The appropriate physical health monitoring has been conducted and reviewed? **Yes / No**

5. Please list below other current medications:

……..

Signed (Prescriber):…… **Print Name**:…… **Date:**……..

Accepted by (Pharmacist)…… **Print Name:**…… **Date:**……

Comments (if any):……

If the request is not for schizophrenia please submit to the Chief Pharmacist or Medical Director for approval or refusal

Decision:	Approved / Refused
Date & Signature:	
Justification for Decision:	

Date Referral form received:…….. **Date first dose dispensed:**…….