**Proforma for Lurasidone Requests**

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| Patient Name:  |   |
| Diagnosis:  |   |
| Inpatient ward/community team:  |   |
| Consultant:  |    |

# Summary

Please provide below a summary of the patient history, including capacity, insight, risk to self, risk to others, urgent or imminent risks or other issues of relevance.

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# Medication History

Please provide details of the previous drug history, including responsivity, compliance, adverse drug reactions and consent.

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# Aripiprazole

If Aripiprazole has not been prescribed previously, please outline why this is not an option for the patient.

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# Clozapine

If the patient has treatment resistant schizophrenia, please outline why Clozapine is not being considered. Please include information on any discussions held with the patient about Clozapine.

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# Risk Factors

Please outline any risk factors for metabolic syndrome e.g. diagnosis of diabetes or hyperlipidaemia, hypertension, BMI or waist circumference outside of recognised normal parameters, increased risk due to ethnic background.

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# Summary

Please summarise the reasons for requesting Lurasidone

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# Consent to Treatment

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Patient has capacity and is consenting to treatment

Patient lacks capacity and treatment will be administered under the Mental Health Act “Mental Capacity Act”

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| **Consultant’s** **signature**   |   | **Date**   |   |
| **Print name**  |   |   |

**ONCE COMPLETED THE FORM SHOULD BE RETURNED TO:**

 **Lisa Ainsworth – Central and West Lancashire Lisa.Ainsworth@lscft.nhs.uk**

 **Tara Gallagher – Fylde and the Bay**

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 **Catherine Harding – Pennine Lancashire and Specialist Services**

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# Outcome

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| Request Approved Request Not Approved: Reason  |    |  |
|   |
| **Signed:**  |   | **Date**  |   |