

# Amiodarone Transfer of Care (ToC) Form

## Section A: to be completed by secondary care

For all patients newly initiated on amiodarone who require ongoing amiodarone therapy: Send referral to GP for ongoing prescription according to the amiodarone Shared Care Protocol (SCP)

The hospital will:

- supply the loading dose
- undertake the baseline tests outlined below

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Hospital No: \_\_\_\_\_

NHS No: \_\_\_\_\_

Consultant: \_\_\_\_\_

*Patient details  
or sticker*

Directorate Cardiology/Cardiothoracic ☐ Other directorate \_\_\_\_\_

Referring consultant details

NGH ☐ RHH ☐ WPH ☐ TRFT ☐

Referring consultant \_\_\_\_\_

Consultant contact # (01709) 424755

Indication Atrial fibrillation/atrial flutter ☐ Other arrhythmias as listed in the SCP \_\_\_\_\_

Maintenance dose: amiodarone 200mg od ☐ or amiodarone \_\_\_\_\_ mg od

Date maintenance dose to start if discharged on loading dose \_\_\_\_\_

**Maintenance doses above 200mg od should be managed by secondary care and are not part of the SCP**

Date initiated \_\_\_\_\_ Intended duration Long term ☐ Other \_\_\_\_\_

Baseline tests done/requested LFTs ☐ TFTs ☐ U&Es ☐ PFTs ☐ CxR ☐

LFTs: liver function tests; TFTs: thyroid function tests; U&Es: urea and electrolytes; PFTs: pulmonary function tests; CxR: chest X-ray

Patient monitoring required at 6 monthly intervals Next monitoring due \_\_\_\_\_

The patient has a hand-held record Tick to confirm as patient must have this ☐

## FORM COMPLETED BY:

Signature: \_\_\_\_\_ Print name: \_\_\_\_\_

Designation: \_\_\_\_\_ Contact No. (bleep/ext.): \_\_\_\_\_ Date: \_\_\_\_\_

GP/practice receiving referral \_\_\_\_\_

Sent by: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_

## Section B: to be completed by the GP & returned for the attention of referring consultant

[rg-h-tr.cardiologysecretaries@nhs.net](mailto:rg-h-tr.cardiologysecretaries@nhs.net)

The above patient has been accepted into our amiodarone monitoring service.

Practice date for next face to face review \_\_\_\_\_

Print name \_\_\_\_\_

Designation \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

*Practice stamp  
(add fax no. below)*

This referral has been made in line with the Shared Care Protocol for amiodarone  
<https://yourhealthrotherham.co.uk/wp-content/uploads/2022/09/Rotherham-Amiodarone-SCP-December-2015-FINAL-MARCH-2016.pdf>

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