## Supporting Resource 2. Paediatric to Adult Transition of Complex or High Cost Medicines (PATCH-Me) Form

**[to be completed by member(s) of Paediatric Transition Team]**

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| **Patient’s full name** | *Complete all details or affix patient label here* |  | | | |
| **Sex** |  male  female | Carer name |  | Relationship of carer |  |
| **D.O.B.** | \_\_/\_\_/\_\_ | Carer phone |  | Carer email |  |
| **Address** |  | General Practitioner name |  | | |
| **Phone number** |  | General Practitioner phone |  | | |
| **Email contact** |  | General Practitioner email |  | | |

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| **Trapeze/ ACI Transition Service referral** | *(Circle)* Yes / No / not applicable (because\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  If Yes,   * provide date of referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * attach [Trapeze referral form](http://www.trapeze.org.au/sites/default/files/SCHN_Trapeze_referral_form_2021_PDF_editable.pdf) / [ACI Transition Service referral form](https://aci.health.nsw.gov.au/networks/transition-care/service) and/or provide contact name, email and phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Consent:** | ☐ I have discussed this referral with the young person and their carer/guardian and they agree their information may be provided to the adult hospital, their general practitioner and other relevant care providers as discussed as part of the transitioning process | | | |
| **Form completed by**  *Paediatric Transition Team Member* | Name | Position | **Contact details** *Phone* | *Email* |
| **Date form sent to adult hospital(s)** |  | | **Date form sent to General Practitioner** | |

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| **PAEDIATRIC hospital service details** | | | | | |
| **Hospital name** |  | **Pharmacy department** | **Contact name** | **Email** | **Phone** |
| **DTC** | **Contact name** | **Email** | **Phone** |
| *Complete this column if more than one specialist caring for patient* | | *Complete this column if more than one specialist caring for patient* | |
| **Specialist name** |  |  | |  | |
| **For treatment of** |  |  | |  | |
| **Date of last paediatric appointment** |  |  | |  | |
| **Email** |  |  | |  | |
| **Phone** |  |  | |  | |

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| **ADULT hospital service details** *(if more than one adult hospital providing ongoing care, complete another form or add another table).* | | | | | |
| **Hospital name** |  | **Pharmacy department** | **Contact Name** | **Email** | **Phone** |
| **DTC** | **Contact Name** | **Email** | **Phone** |
| **Date of expected transfer of services** |  | *Complete this column if more than one specialist caring for patient* | | *Complete this column if more than one specialist caring for patient* | |
| **Specialist name** | **1.** | **2.** | | **3.** | |
| **For treatment of** |  |  | |  | |
| **Date of appointment** |  |  | |  | |
| **Email** |  |  | |  | |
| **Phone** |  |  | |  | |

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| **Medication List (add more rows as required)** | | | | | | |
| Medication | Form | Dose | Indication | Proposed supply~ | Further information^ | Comments/Checklist |
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~Proposed supply may include: adult hospital, paediatric hospital, community pharmacy, sponsor.

^Further information may include: PBS, non-PBS; SAS medicine; off-label use; via Medicine Access program (MAP); requires special prescribing rights; requires DTC approval; private script; over the counter; compounded.