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]

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			

Trapeze/ ACI Transition Service referral	*(Tick)* Yes / No / not applicable (because________________________________) If Yes, • provide date of referral ________________ • attach Trapeze referral form / ACI Transition Service referral form 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**	

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	1.	2.		3.	
For treatment of					
Date of last paediatric appointment					
Email					
Phone					

<table>
<tr><td colspan="6">ADULT hospital service details (if more than one adult hospital providing ongoing care, complete another form or add another table).</td></tr>
<tr><td rowspan="2">Hospital name</td><td rowspan="2"></td><td>Pharmacy department</td><td>Contact Name</td><td>Email</td><td>Phone</td></tr>
<tr><td>DTC</td><td>Contact Name</td><td>Email</td><td>Phone</td></tr>
<tr><td>Date of expected transfer of services</td><td></td><td colspan="2">Complete this column if more than one specialist caring for patient</td><td colspan="2">Complete this column if more than one specialist caring for patient</td></tr>
<tr><td>Specialist name</td><td>1.</td><td colspan="2">2.</td><td colspan="2">3.</td></tr>
<tr><td>For treatment of</td><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>Date of appointment</td><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>Email</td><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>Phone</td><td></td><td colspan="2"></td><td colspan="2"></td></tr>
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Medication List (add more rows as required)

Medication	Form	Dose	Indication	Proposed supply~	Further information^	Comments/Checklist

~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.