

ENOXAPARIN (Clexane®) SHARED CARE FORM

**For all patients requiring ongoing enoxaparin therapy:
email this referral to GP for ongoing prescription according
to the Enoxaparin Shared Care Protocol**

Hospital to provide initial 28-day supply of enoxaparin and to undertake
heparin-induced thrombocytopenia (HIT) monitoring if required.

Patient's medical care remains with the hospital consultant who initiated enoxaparin.
GP to continue prescribing and carry out further monitoring as appropriate.

Name:

DoB:

Affix patient label here

Hosp No.:

NHS No.:

Consultant:

1) REFERRING CONSULTANT DETAILS

Referring consultant: _____

DRI []

BDGH []

Consultant email address: _____

Next consultant clinic appointment date: _____ GP/practice receiving referral: _____

2) INDICATION FOR ENOXAPARIN

a) Thromboprophylaxis: In pregnancy ☐

Central line ☐

Cancer ☐

b) Deep vein thrombosis/ Pulmonary embolism:

In pregnancy ☐

Injectable drug user ☐

Associated with cancer/ cancer therapies ☐

Unsuitable for oral anticoagulation ☐

3) TREATMENT INFORMATION

Patient's weight _____ (kg) Dose of enoxaparin _____ mg ONCE/TWICE daily (delete as appropriate)

Date started _____

Intended dose changes (if applicable):

Dose to change to _____ units ONCE/TWICE daily (delete as appropriate) on (date) _____

Proposed duration of treatment:

3 months ☐ 6 months ☐

LIFELONG ☐

DURATION OF PREGNANCY ☐

Enoxaparin to be administered by: Patient or carer ☐

District Nurse (send this form along with DN referral) ☐

4) MONITORING REQUIREMENTS

Baseline results

Creatinine: _____ (μmol/L) Creatinine clearance: _____ (mls/min) Platelets: _____ (x10⁹/L) Potassium: _____ (mmol/L)

FORM COMPLETED BY:

Signature: _____ Print name: _____

Designation: _____ Contact No.(bleep/ext.): _____ Date: _____

Emailed to: _____ GP/ Practice at Time: _____ Date: _____

By: _____ Time: _____ Date: _____

PRIMARY CARE TO COMPLETE:

I _____ (insert name of primary care clinician) can confirm I:

☐ **Accept** the request to participate in shared care for the patient named above and will complete the monitoring as set out in the shared care protocol for this medicine/ condition

☐ **Reject** the request to participate in shared care; the reason for this being (optional).....

Signature of primary care clinician (Doctor/ Nurse/ Other): _____ Date: _____

GP/ practice receiving referral: _____ Emailed by: _____ Date: _____