MELATONIN – Circadin® (off label use) for the treatment of persistent sleep disorders in children over 3 years old with ADHD

Transfer of prescribing to GP

Patient details / addressograph:

Name: ……

Address: ……..

……

D.O.B: ……..

Hospital No: ……

The following test, investigations have been carried out:

Weight: (including centiles) Date:

Height: (including centiles) Date:

Sexual development: Date:

Medication initiated on (date):

Patients last clinic visit on (date):

At the last patient review Melatonin appeared to be effectively controlling symptoms'/providing benefit to sleep

YES / NO

The patient has been stabilised on a dose of: ……..

I will arrange to review this patient on (date): ……,then every 12 months.

Consultant Name: ……..

Consultant Signature: ……..

Address: ……

Contact Number: ……

GP: ……..

Address: ……

……

Contact Number: ……