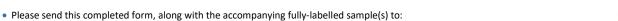
## PROFORMA 521: CLOZAPINE ASSAY REQUEST FORM

## **CLOZAPINE ASSAY REQUEST FORM**





• PLEASE USE PURPLE-TOPPED (EDTA) SAMPLE TUBES, AND COLLECT SAMPLES PRE-DOSE (i.e. 'TROUGH')

Analytical Services International Ltd., Jenner Wing, St. Georges University of London, Cranmer Terrace, London, SW17 ORE

PART 1. Patient Details																			
Last Name									First Name										
Hospital No.	).								NHS No										
Monitoring Service Number																			
DOB	D D M M Y Y			Υ	Υ		Sex	ex M			/ F We			eight (kg)					
PART 2. Sample Information																			
Date of Sample		D	D	M	M	Υ	Υ	Υ	Υ	Time of Sample			mple	Н	Н		М	M	
Date of Last Dose		D	D	M	М	Υ	Υ	Υ		Time of Last Dose			t Dose	Н	Н		M	M	
<b>Current Dose</b>		Dose sp				plit	AM	AM Lunchtime					PM Evening						
Smoker? □	□ Non-smoker □ <10/day □ 10-20/day □ >20/day □ Nicotine replacement □ Vapes/e-Cigarettes											ttes							
Reason for ☐ Baseline ☐ Poor/non-compliance? ☐ Dose correct? ☐ Drug interaction? ☐ Adverse reaction? ☐ Other? Please specify:													ion?						
Other medication(s)? Please list																			
PART 3. Report and Invoice																			
							Te	el. No:											
Requestor							E	mail:											
Consultant (if different from abov							1 -	el. No mail:	:										
Address for Report (include Ward name if applicable)																			
												Po	stcode:						
Address for Invoice (if different from above)																			
										□NH	IS Tr	rust	☐ Pri	vate Org	ganisat	ion	□ No	on-UK	
PO Number																			