**CLOZAPINE ASSAY REQUEST FORM**

* Please send this completed form, along with the accompanying fully-labelled sample(s) to:

**Analytical Services International Ltd., Jenner Wing, City St. Georges University of London, Cranmer Terrace, London, SW17 0RE**

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

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| *PART 1. Patient Details*  |
| Last Name |  | **First Name** |  |
| Hospital No. |  | **NHS No.** |  |  |  | - |  |  |  | - |  |  |  |  |
| Monitoring Service Number |  |
| DOB | **D** | **D** | **M** | **M** | **Y** | **Y** | **Y** | **Y** | **Sex** | **M / F** | **Weight (kg)** |  |

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| *PART 2. Sample Information* |
| Date of Sample | **D** | **D** | **M** | **M** | **Y** | **Y** | **Y** | **Y** | **Time of Sample** | **H** | **H** | **M** | **M** |
| Date of Last Dose | **D** | **D** | **M** | **M** | **Y** | **Y** | **Y** | **Y** | **Time of Last Dose** | **H** | **H** | **M** | **M** |
| Current Dose (mg/d) |  | **Dose split** | *AM* | *Lunchtime* | *PM* | *Evening* |
| Smoker? | 🞏 Non-smoker 🞏 <10/day 🞏 10-20/day 🞏 >20/day 🞏 Nicotine replacement 🞏 Vapes/e-Cigarettes |
| Reason for Request? | 🞏 Baseline 🞏 Poor/non-compliance? 🞏 Dose correct? 🞏 Drug interaction? 🞏 Adverse reaction? 🞏 Other? *Please specify:*  |
| Other medication(s)? *Please list* |

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| *PART 3. Report and Invoice* |
| Requestor |  | **Tel. No:****Email:** |  |
| Consultant *(if different from above)* |  | **Tel. No:****Email:** |  |
| Address for Report (include Ward name if applicable) Postcode: |
| Address for Invoice *(if different from above)* 🞏 NHS Trust 🞏 Private Organisation 🞏 Non-UK |
| PO Number |  |