

PROFORMA 521: CLOZAPINE ASSAY REQUEST FORM

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')

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)	

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?	<input type="checkbox"/> Non-smoker <input type="checkbox"/> <10/day <input type="checkbox"/> 10-20/day <input type="checkbox"/> >20/day <input type="checkbox"/> Nicotine replacement <input type="checkbox"/> Vapes/e-Cigarettes												
Reason for Request?	<input type="checkbox"/> Baseline <input type="checkbox"/> Poor/non-compliance? <input type="checkbox"/> Dose correct? <input type="checkbox"/> Drug interaction? <input type="checkbox"/> Adverse reaction? <input type="checkbox"/> Other? Please specify:												
Other medication(s)? Please list													

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)			
<input type="checkbox"/> NHS Trust <input type="checkbox"/> Private Organisation <input type="checkbox"/> Non-UK			
PO Number			

Analytical Services International Ltd.

Clozapine Request Form (Word) - Version: 4.0, Index: ASI Proforma 521, Printed: 14-Dec-2025 16:38

VAT No GB-468 2066 74, Registered in England & Wales No. 02704238

Authorised on: 12-Nov-2025, Authorised by: Abraham Ali and Lewis Colclough, Document Unique Reference: 1622-134220997, Due for review on: 12-Nov-2029

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