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? ☐ 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*

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	