**ANTIPSYCHOTIC ASSAY REQUEST FORM**

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

**Analytical Services International Ltd., Jenner Wing, 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.** | |  |  |  | - |  |  |  | - | |  |  |  |  |
| DRUG ASSAY REQUIRED | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| 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 |  | | |