

ANTIPSYCHOTIC 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.								
DRUG ASSAY REQUIRED																	
Monitoring Service Number																	
DOB										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:								
Consultant (if different from above)				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												