

# CLOZAPINE 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.				-			-	
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 <i>(if different from above)</i>		Tel. No:	
		Email:	
Address for Report			
Postcode:			
Address for Invoice <i>(if different from above)</i>			
<input type="checkbox"/> NHS Trust <input type="checkbox"/> Private Organisation <input type="checkbox"/> Non-UK			
PO Number			

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Analytical Services International Ltd. Directors, Prof. A Johnston, S J Hollington, Prof. DW Holt

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