PLASMA CLOZAPINE ASSAY REQUEST FORM

***** Use separate form for other antipsychotic drug assay requests *****

Please send completed form with a blood sample (**2 ml** collected into **EDTA** tube or **1ml EDTA** plasma) to:

TOXICOLOGY, 1st floor Synnovis, Friars Bridge Court, 41-43 Blackfriars Road, London, SE1 8NZ
Tel: 0204 591 0056 or 0204 591 0054, e-mail: toxicologystaff@synnovis.co.uk

For result enquiries please contact customer services

Tel: 020 4513 7300 e-mail: *customerservices@synnovis.co.uk*

**** Pack safely to Post Office regulations - Do not send with courier for FBC ****

- Samples should be taken 12 hours post-dose, collected prior to the morning sample in twice-daily dosing ("trough sample")
- **Addresses** to which the **report** is to be sent **must** be supplied; the **report** will be addressed to the **consultant**, unless otherwise specified.
- Assay results will be available within 2 working days of sample receipt
- ***For information about electronic reporting please contact customer services***

Patient

Last name:		
First name(s):		
Clozapine Monitoring Service number:		
NHS or Hospital number:		
Date of birth:	*Sex:* M / F	*Weight (kg):*
Date and time sample taken? DD / MM / YY	*(24-hour clock)* h : m	
Date and time of last clozapine dose? DD / MM / YY	*(24-hour clock)* h : m	
Clozapine dose (mg/d)?	*Smoker?* ☐YES ☐NO (includes eCig/NRT)	

Please affix CPMS, DMS, ZTAS or alternative label here if available

Report and invoice

Assay requested by:
Phone number:
Email address:
Consultant:
Address for report: *Postcode*   *If this service has recently moved, please tick here* ☐
Invoicing; is the organisation: NHS / Private / Non-UK   *Invoice address:*   *Purchase order number:*

Reason for request:

☐ Baseline value?	☐ Poor / non-compliance?
☐ Dose correct?	☐ Drug interaction?
☐ Adverse reaction?	☐ Other (describe below)?

Other medication (please detail):

This form may be downloaded from http://www.synnovis.co.uk/our-tests/clozapine-norclozapine